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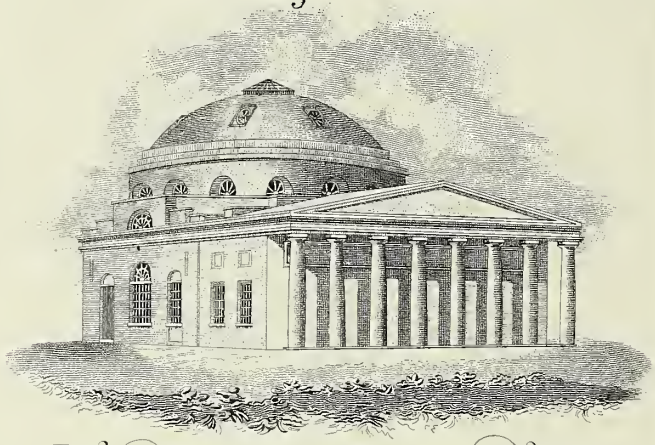

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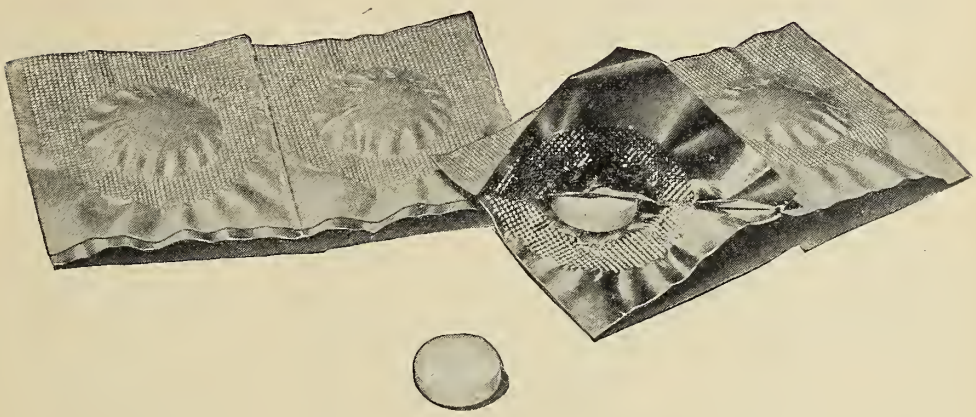

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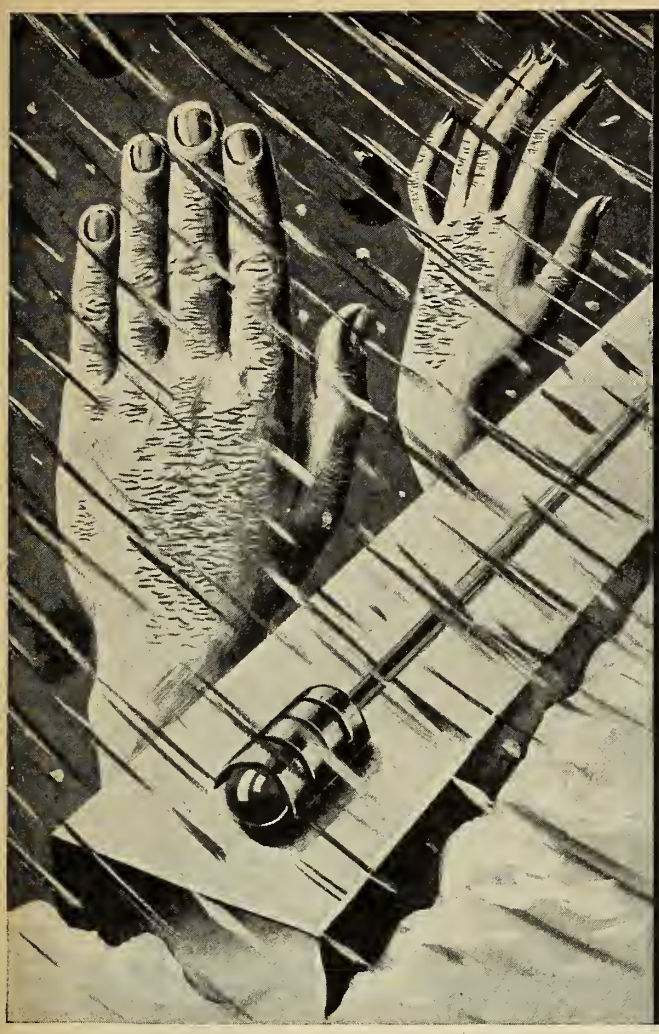

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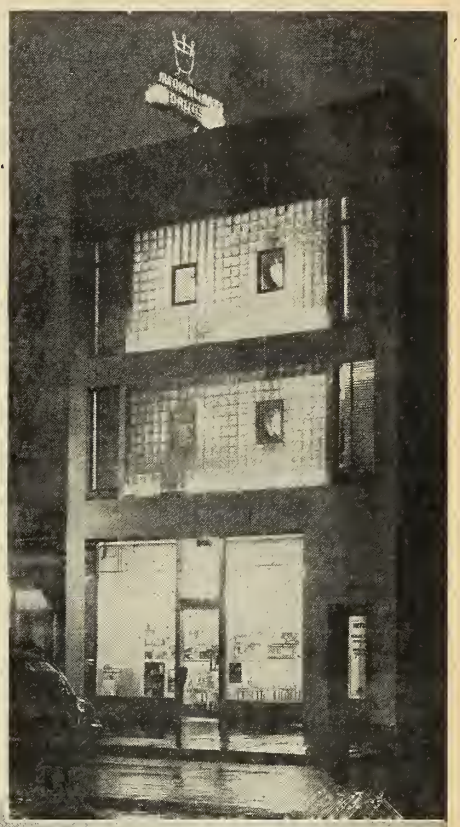

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MISSISSIPPI VALLEY MEDICAL SOCIETY 1947 ESSAY CONTEST

The Seventh Annual Essay Contest of the Mississippi Valley Medical Society will be held in 1947. The Society will offer a cash prize of $100.00, a gold medal, and a certificate of award for the best unpublished essay on any subject of general medical interest (including medical economics and education) and practical value to the general practitioner of medicine. Certificates of merit may also be granted to the physicians whose essays are rated second and third best. Contestants must be members of the American Medical Association who are residents of the United States.

The winner will be invited to present his contribution before the Twelfth Annual Meeting of the Mississippi Valley Medical Society to be held at Burlington, Iowa, October 1, 2, 3, 1947, the Society reserving the exclusive right to first publish the essay in its official publication—the *Mississippi Valley Medical Journal* (incorporating the *Radiologic Review*). All contributions shall be typewritten in English in manuscript form, submitted in five copies, not to exceed 5000 words, and must be received not later than May 1, 1947.

The winning essays in the 1946 contest appear in the January 1947 issue of the *Mississippi Valley Medical Journal* (Quincy, Illinois).

Further details may be secured from Harold Swanberg, M.D., Secretary, Mississippi Valley Medical Society, 209-224 W.C.U. Building, Quincy, Illinois.

FELLOWSHIP IN THE AMA

The American Medical Association is going to celebrate its centennial in Atlantic City, June 9-13, 1947. Elaborate plans are being made for this celebration.

Only Fellows and invited guests are eligible to attend. Membership in your state society is the primary qualification for Fellowship in the AMA. Fellowship dues and subscription to *The Journal AMA* are both included in one annual payment of $8.00 which is the cost of *The Journal* to subscribers who are not Fellows.

If you are not a Fellow and plan to attend the Atlantic City session, which will be a milestone in medical history, you can save yourself considerable time and confusion when registering, if you will write now to the American Medical Association, 535 North Dearborn Street, Chicago 10, and ask if you are eligible to become a Fellow.

POLIOMYELITIS AND RECENT TONSILLECTOMY

Anderson reports that a severe epidemic of poliomyelitis occurred in Utah in 1943. Of the hospitalized patients, 31.6 per cent had the bulbar or bulbospinal type. A state-wide survey showed the number of tonsillectomies performed to be 1,411 in July, 2,111 in August, and 677 in September. Seventeen of these children developed poliomyelitis within thirty days after operation; all the patients had either the bulbar or bulbospinal type of poliomyelitis. During the same three-month period, 261 cases of poliomyelitis were reported in the state, in which 232 patients were children between the ages of three and sixteen. The incidence of poliomyelitis in the tonsillectomized group was 0.40 per cent, or about two and a half times greater than the 0.15 per cent incidence of poliomyelitis in the child population of the same age group. The total number of bulbar or bulbospinal cases of poliomyelitis in children three to sixteen years of age was thirty-nine; and seventeen (46 per cent) of these cases had been preceded by a recent tonsillectomy. A comparison of the incidence of bulbar cases in the general child population with the incidence in the tonsillectomized group showed that, during this epidemic, the possibility of contracting bulbar poliomyelitis was sixteen times greater in children immediately after tonsillectomy than in children in the general population.—J. A. Anderson, *Journal of Pediatrics,* quoted in *New England Medical Journal.*

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If you are participating in the Veterans Administration program of medical treatment for disabled veterans of World War II, you may save office time and personal time by requesting prescription blanks from your druggist with the physician's authorization already in print upon the

(Continued on Page 16)

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In the first stage of therapy, prophylaxis, the establishment of a moderate blood level of penicillin has been shown to be effective in reducing postoperative infections. This is particularly true in tonsillectomies. Here, a tablet of buffered penicillin every two hours, day and night, for 24 hours before the operation is a simple, yet effective means of avoiding secondary inflammation due to penicillin-sensitive organisms. For such prophylaxis, tablets of calcium penicillin, 50,000 units each, are available in bottles of 12.

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(Continued from Page 14)

blank. The Michigan State Pharmaceutical Association states that many drug stores throughout the state have these prescription blanks on hand and will be glad to furnish copies to the doctor.

A sample copy of the blank being used by the "fee designated physician and pharmacist" follows:

Date.....

Name .....

Address .....

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(1) "I am authorized to treat and prescribe for the above named Veterans Administration's patient."

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(3) "I certify that this is a true copy of Prescription No. ..... on file under that number at the....."

ELIGIBILITY FOR EMIC

With the enactment of the "Armed Forces Leave Act of 1946" under which enlisted men are paid for the number of days of accumulated leave at the time of their discharge, questions have arisen regarding the eligibility of wives and infants of discharged servicemen under the Emergency Maternity and Infant Care program.

The date of separation or discharge of the serviceman from the armed forces is the date used in determining eligibility under the EMIC program. The number of days accumulated leave for which the enlisted man is paid at that time in no way affects the actual date of separation or discharge. Therefore, if the wife of a serviceman becomes pregnant after the date of separation, she is not eligible for maternity care under the program.

COMMITTEE ON AWARDS

This Committee of the Michigan State Medical Society was named recently to formulate procedures and recommend policies which would permit the Michigan State Medical Society properly to honor those lay organizations and lay personages (example: radio stations, newspapers, business organizations, civic and professional leaders) who, in the opinion of the Society, have contributed services of outstanding worth in the cause of health for the people of Michigan.

The Committee recommended that the following procedures be followed in determining to whom the awards shall be made:

1. Nominations for awards to be made by resolution of the House of Delegates, The Council of the Michigan State Medical Society, or the County Medical Societies.

2. The Committee on Awards shall consider all nominations and present its recommendations for awards and grades of awards for approval at the subsequent meeting of The Council.

3. In considering the nominations, the Committee on Awards will weigh, to the best of its ability, the worth of the services contributed by the nominees in relation to a high standard of

(a) Accomplishment

(b) Effort

(c) Sacrifice

—as they involve the good interests of the health of the people.

The Committee recommended that the citation be one of three grades:

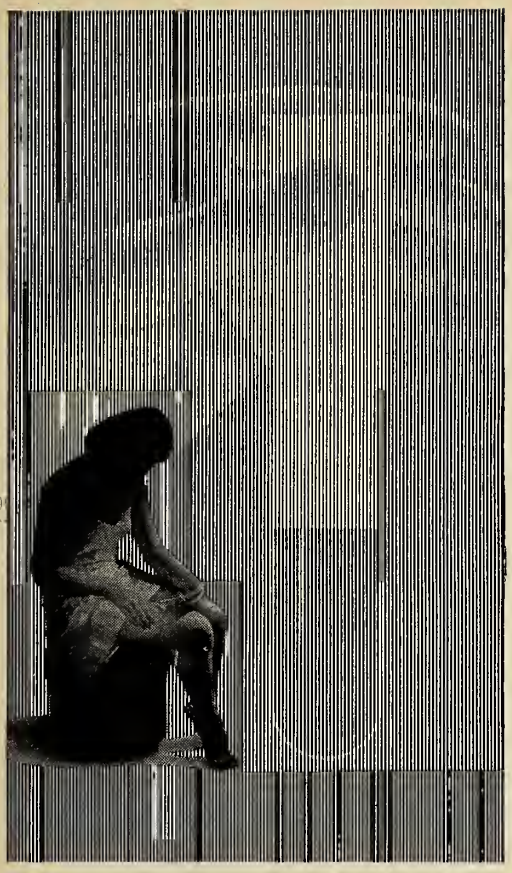
1. A letter of commendation on heavily embossed stationery suitable for framing and signed by the President, Chairman of The Council and the Secretary of the Michigan State Medical Society.

2. A printed certificate of accomplishment on parchment paper, suitable for framing and carrying the seal of the Michigan State Medical Society as well as the signatures of the President, Chairman of The Council and Secretary.

3. A hand-illuminated scroll on parchment citing the accomplishment for which the award was granted and signed by the MSMS President, President-elect, Secretary, Treasurer, Speaker, Vice-Speaker, Chairman of The Council, Vice-Chairman of The Council and the Chairman of the Committee on Awards.

The Committee recommended that the citations be made at a public meeting by the officers of the MSMS or by their authorized representatives upon those occasions most suitable to the recipient of the award. This would not preclude the bestowal of the award at any meeting of the MSMS or of the component County Medical Societies. It was recommended that these citations not be mailed to their recipients. The award should be made in person and if possible in public and be accom-

(Continued on Page 24)



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ESTIMATING THE DOSAGE: The simplest method is to start with 15 units of Globin Insulin and increase the dosage every few days, as required. A closer estimation is obtained by quantitative sugar determination of a 24-hour urine specimen. For the initial dosage, ⅔ of a unit of Globin Insulin is given for every gram of sugar spilled in 24 hours.

Both diet and dosage must subsequently be adjusted to meet the needs of each individual patient.

ADJUSTING THE DIET: In general it has been found that a good carbohydrate distribution for the patient on Globin Insulin consists of 1/5 of the total carbohydrate at breakfast, 2/5 at the noon meal, and 2/5 at the evening meal. Any tendency toward midafternoon hypoglycemia may usually be offset by giving 10 to 20 grams of carbohydrate between 3 and 4 p.m.

This starting diet may subsequently be adjusted as required to suit the needs of the patient. Final adjustment of carbohydrate distribution may be based on fractional urinalyses.

ADJUSTING TO 24-HOUR CONTROL: Simultaneously adjust the Globin Insulin dosage to provide 24-hour control as evidenced by a fasting blood sugar level of less than 150 mgm., or sugar-free urine in the fasting sample.

'Wellcome' Globin Insulin with Zinc is a clear solution, comparable to regular insulin in its freedom from allergenic properties. Available in 40 and 80 units per cc., vials of 10 cc. Accepted by the Council on Pharmacy and Chemistry, American Medical Association. Developed in The Wellcome Research Laboratories, Tuckahoe, New York. U.S. Patent No. 2,161,198. LITERATURE ON REQUEST.

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(Pledge Card on Page 28)

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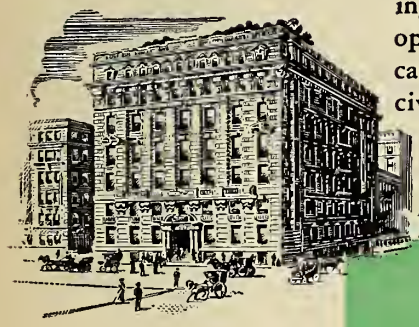

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"I want to commend someone on a classic."—John Hunton, California Medical Association.

* * *

" . . . find it to be very much in keeping with Alabama's thinking. It seems to be sound in all particulars." —Douglas L. Cannon, M.D., Secretary, Medical Association of the State of Alabama.

* * *

"I have gone through it at least twice and believe it to be exceptionally sound. . . . I will appreciate receiving about twenty-five additional copies."—C. H. Crownhart, Secretary, State Medical Society of Wisconsin.

* * *

"Not only am I deeply impressed by the value of the Michigan booklet and the evident labor that went into its preparation but it seems most timely for consideration by members of our Conference Executive Committee. . . . You will find it worth your study."—H. T. Sethman, Secretary-Treasurer, Conference of Presidents of State Medical Societies.

* * *

"I have examined and think it ideal for your state. It is a most comprehensive and laudable plan. . . . I thank you for it."—George C. Hulley, M.D., President, Idaho State Medical Association.

* * *

"It will be of inestimable aid in developing our own modest program."—E. F. Engebretson, Executive Secretary, North Dakota State Medical Association.

* * *

"Congratulations . . . to the medical people of your state on the Public Relations Plans of the Michigan State Medical Society . . . most comprehensive . . . one of the finest pieces of work I have seen in any state . . . you have definite suggestions many of which we shall be able to use to good advantage."—Henry S. Johnson, Public Relations, Medical Society of Virginia.

* * *

"At its last meeting held a few days ago, the Board of Trustees considered your Public Relations program in some detail, each member having read it from cover to cover within the preceding week. The Board, by a formal motion, directed me to express to you and through you to the Michigan State Medical Society our organization's deep appreciation for the co-operation your Society has demonstrated in supplying this material to us. I should add that the Board of Trustees is enthusiastic and highly complimentary concerning the program that you have developed and had outlined in this booklet. Without any doubt this publication of the Michigan State Medical Society will form a considerable part of the pattern of our own Colorado Public Relations program next year."—Harvey T. Sethman, Executive Secretary, Colorado State Medical Society.

* * *

"It is exactly the program which I have suggested to our State Medical Society. I can honestly say that I highly approve of the background of the Plan, but I was particularly interested in the concrete method of its being set up."—W. L. Estes, Jr., M.D., President, Pennsylvania State Medical Society.

STOP—LOOK—LISTEN. . . .

STOP telling the patient that there is nothing wrong with him but nerves. Don't say, "Go home and forget it."

LOOK for the facts as the patient sees them.

LISTEN attentively to the patient's story.

* * *

We shall make progress in solving the mental health problems when we realize that the person showing signs of developing a pathological personality is as sick as the one with tuberculosis and requires as early treatment.

* * *

Parents who teach their children that to fail is a disgrace are responsible for a surprisingly large amount of emotional instability.

* * *

The patient who is always worrying usually has conflicts—probably nonconcious—the conflicts come to the surface in socially acceptable worries.

* * *

The treatment of any severe disorder is incomplete unless it includes the treatment of the person himself.

* * *

Each neurotic symptom has a meaning all its own.

* * *

Emotional poverty is worse than financial poverty.

* * *

An adolescent should be treated as such. He is neither a child nor an adult.

—Committee on Mental Hygiene

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Army Medicine

ARMY REPORTS ON USE OF STREPTOMYCIN

The new anti-infection agent, streptomycin, which is in the same general class as penicillin, appears effective in appropriate doses against more than half the infective bacterial organisms ordinarily encountered by surgeons, according to the report from the Halloran General Hospital. Clinical studies of the use of the drug throughout the army have been submitted and evaluated at Halloran.

On the other hand, it apparently has specific poisonous effects when given ever an extended period, and bacteria soon become resistant to it so that it probably can be used only once with maximum effect within a limited period on the same patient.

The drug became available only late in the war and is still scarce and expensive.

Army experience with the drug is probably the most extensive to date due to the ability to compile and follow results. Outside the services because of limited opportunities to observe results in large numbers there have been varied, and sometimes quite exaggerated, reports on its value and it often is referred to popularly as a "miracle drug." From the first, careful observation of its effects have been carried out by army doctors and these are being continued. The findings to date are summarized in the Army Medical Bulletin of November, 1946.

The observation of the ability of bacteria to develop resistance to the drug after a few days may be of particular importance at this time. The same has been noted in respect to both the sulfa drugs and penicillin, but apparently the phenomenon is more pronounced with streptomycin. In at least one case, test tube experiments showed, there was a 100-fold increase of the resistance of an organism in ten days. Given indiscriminately, the drug may lose any value for a particular type of infection in an individual for the rest of his life. Improper use may cause variation and selection in disease agents so that streptomycin is no longer effective for the infection where it is of greatest value at the present time.

Bacteria, on the basis of certain chemical reactions, ordinarily are divided into two classes—Gram positive and Gram negative. The new drug, in test tube experiments, seems effective, in varying concentrations, against 60 per cent Gram positive and 80 per cent Gram negative organisms ordinarily encountered in surgery.

Of paramount importance, is determination whether a specific microorganism is susceptible to the drug before it is administered by mouth, by injection, or direct application.

The army experience bears out previous claims that streptomycin is of especial value in clearing up infections of the urinary tract, provided that the organisms causing the infections are susceptible ones. If the treatment is not entirely effective in three days ordinarily no good results can be expected from its continuation. In gonorrhea infection which has proved resistant to both sulfadiazine and penicillin outstanding results have been obtained.

Use in army hospitals gives no support to claims that the drug is of value in infections of the prostate. The drug is not concentrated in that organ.

It was found to have very little value against bone infection, except when used in conjunction with surgery where there could be direct application.

Thus far streptomycin has not given dramatic results in peritonitis, but its continued use as an auxiliary treatment seems justified.

In various dysenteries due to susceptible bacteria considerable benefit has been noted, sometimes when the drug is given by mouth alone.

In septicemia—still provided that the organism responsible for the infection is a susceptible one—streptomycin has proved very effective, but it is still essential that unapproachable foci of infection be removed by surgery.

The substance has little value, so far as the army experience goes, against typhoid fever and it is apparently of no use in controlling carriers of this disease.

In undulant fever there have been apparent clinical arrests of the infection from the combined use of streptomycin and sulfadiazine after each drug given alone had failed. Further study will be required, however, before any valid conclusions can be reported.

It is very effective against tularemia, or rabbit fever, provided the specific organism responsible has been demonstrated in test tube experiments to be susceptible to the drug.

Up to date, experience with only a few cases of meningitis have been reported and the results, in conjunction with other treatments, have been quite good. The Army doctors found, however, that it must be given by injection into the space between the thick membranes surrounding the brain and spinal cord and the brain or spinal cord tissue. Circulating in the blood stream, it cannot pass this barrier to reach the infecting organisms.

Excellent results have been obtained with direct application of the drug to infections of the external ear, the pleural cavities and the brain. Infections elsewhere will not reach local foci of infection in sufficient concentration to be effective.

One of the hopes of the medical profession has been that streptomycin would prove of some value against tuberculosis. The army experience neither confirms nor refutes this since a much longer series of investigations will be required before there can be any valid conclusions.

Balances against the demonstrated value of streptomycin in suitable cases are some apparently toxic effects. Some of these are probably due to impurities in the drug but others seem to be specific for the drug itself.

(Continued on Page 24)

NO. 7 in Schenley Laboratories' continuing summary of penicillin therapy.

EMPYEMA: treatment with PENICILLIN SCHENLEY

Penicillin exhibits a marked ability to sterilize pleural effusions whenever the infecting organisms are penicillin-sensitive. It is most effective when administered in large doses during the incipient stages. Patients should be observed carefully for at least two weeks after discontinuance of penicillin therapy to avoid possible recurrence.[1]

In the management of empyema, it is especially appropriate to apply the maxim:

give enough-soon enough-long enough

1. Poppe, J. K.: J.A.M.A. 129: 435 (Oct. 6) 1945.

PENICILLIN SCHENLEY. Treatment: Penicillin solution is injected directly into the pleural cavity after aspiration and after irrigation with sterile isotonic salt solution, if necessary. Penicillin should not be used for irrigation. The optimum dose for each injection is 50,000 to 200,000 units in a volume of solution less than the amount of fluid or pus aspirated. The frequency of injections depends on the extent, type, and severity of the infection, and the response to therapy. Treatment should be continued until after the fluid becomes sterile.

Surgical intervention is necessary if fibrin masses or loculation prevent adequate aspiration or if penicillin therapy is ineffective, as indicated by persistence of positive cultures after one week.

SYSTEMIC THERAPY. Systemic use of penicillin is indicated as a supplement to intrapleural therapy particularly where there exists an underlying active pulmonary infection or a bronchopleural fistula.

SCHENLEY LABORATORIES SERVICES:

1. Penicillin Paragraphs for January, deoling with empyema, has been mailed to all physicians.
2. A comprehensive penicillin dosage chart will be mailed to physicians on request.

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ARMY REPORTS ON USE OF STREPTOMYCIN

(Continued from Page 22)

The most serious of these is what seems to be an irreversible damage to part of the eighth cranial nerve which appears when streptomycin is given in large doses by injection for more than ten days. This means that one's sense of balance may be disturbed for a long time, with possible attacks of dizziness and nausea. This was found in two army cases. A third patient showed partial deafness, indicating that there had been a poisonous effect on the other portion of the eighth cranial nerve, which is the path of hearing. Toxic effects also were noted on the kidneys. All this demonstrated that the drug should be given only by physicians and then only after careful consideration of the organisms involved and the safe dosage.

ARMY MEDICAL OFFICERS FIND REAL "SHELL SHOCK" CASES

Real "shell shock"—a relatively rare condition—has been found by Army medical officers. It is a hitherto undescribed medical syndrome—which means a complex of symptoms. It is a mental and physical condition due entirely to the effect of blast on the tissues of the brain.

In World War I, practically every neuropsychiatric case resulting from combat was labelled "shell shock" until it was discovered that many such cases had never been within miles of an exploding shell. This made the term meaningless and it was dropped altogether from medical language, although it persisted among the lay public.

The majority of combat breakdowns in World War II were labelled "combat fatigue" and special centers were set up back of the front for dealing with them. Naturally all the causes which bring about nervous and mental conditions among men anywhere also operated in the Army.

It proved extremely difficult to isolate any brain syndrome due to blast waves alone. Usually, where they were suspected, the indications were that the blast waves had served only to exaggerate and bring to the fore previously existing pathological conditions.

Now the existence of a limited number of cases of pure shell shock—now called "closed head injury syndrome due to blast"—is established by an intensive study reported in the October issue of the Bulletin, official Medical Corps publication.

Thirty-four cases were studied in which no other cause for the pathological condition could be found. The men were studied from 50 days to a year after being subjected to the blast waves.

The main complaints of the blast group were headache, ringing in the ears, deafness and anxiety. Other symptoms included dizziness, (not true vertigo), daze and confusion, sudden attacks in which everything went black, weakness, fatigue, chest pains and backache. Apathy, mental lethargy and many physical complaints were also reported.

When seen two to twelve months after injury the syndrome complex was little changed. Ringing in the ears had disappeared in some cases and deafness had improved considerably. Backaches, dizziness and blackouts still were mentioned frequently. When questioned none of the men would acknowledge retention of even 75 per cent normal energy. A third indicated poor memory for recent events but in none was memory loss a disability. Moderate depression was noted in several.

"In the total synthesis a more concrete concept of the syndrome emerges," the report said. "The men had been stunned and often rendered unconscious by nearby blast. Two-thirds of the group had been unconscious. A third showed ruptured eardrums. Anxiety tension or dullness and apathy were present in 65 per cent. Headaches were heterogeneous in character. They were usually described as a 'dull ache' or sharp jabs of pain in the scalp. About twenty per cent showed minor but definite neurological changes."

Whether there is definite alteration in the brain has been impossible to determine. The indications are, however, that this is true. Even so, the study explains, it need not cause any permanent mental or nervous disability and on the whole the prognosis for shell shock is good.

COMMITTEE ON AWARDS

(Continued from Page 16)

panied by appropriate remarks on the part of the individual representing the MSMS.

The recommendations of the MSMS Committee on Awards were approved by the Executive Committee of The Council on November 20, 1946.

MICHIGAN STATE FARM BUREAU APPRECIATES MICHIGAN MEDICINE

"We desire to express appreciation to the Michigan State Medical Society for its interest in problems of rural health and its desire to develop services which will more adequately protect the health of farm people. We offer our co-operation to the State Medical Society and express a willingness to work with it jointly in the development of rural health services. To this end we urge an increased interest on the part of the men and women of the Farm Bureau in matters of rural health and urge our State Board of Directors to co-operate with the Medical Society in any way that is feasible and logical."

—Resolution adopted by Michigan State Farm Bureau at its 1946 annual meeting.

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Michigan Postgraduate Clinical Conference

The first annual Michigan Postgraduate Clinical Conference, featuring an all-Michigan program, will be held at the Book-Cadillac Hotel, Detroit, Tuesday, Wednesday, Thursday, Friday, March 12-14, 1947. The Conference is sponsored by the Michigan State Medical Society in co-operation with the Wayne County Medical Society, University of Michigan Medical School, Wayne University College of Medicine, University of Michigan Department of Postgraduate Medicine, and the Michigan Foundation for Medical and Health Education.

The Committee on Arrangements and Program is composed of G. C. Penberthy, M.D., Detroit, Chairman, L. Fernald Foster, M.D., Bay City, Secretary, D. C. Beaver, M.D., Detroit, B. B. Bushong, M.D., Traverse City, E. I. Carr, M.D., Lansing, F. A. Coller, M.D., H. H. Cummings, M.D., A. C. Furstenberg, M.D., all of Ann Arbor, S. W. Hartwell, M.D., Muskegon, Hardy A. Kemp, M.D., Detroit, A. H. Kretchmar, M.D., Flint, R. D. McClure, M.D., Detroit, H. R. Prentice, M.D., Kalamazoo, E. D. Spalding, M.D., Detroit, C. C. Sturgis, M.D., Ann Arbor, F. A. Weiser, M.D., Detroit, and Merrill Wells, M.D., Grand Rapids.

All members of the Michigan State Medical Society are invited and urged to attend the Michigan Postgraduate Clinical Conference. For hotel accommodations write E. C. Texter, M.D., Chairman, Housing Committee, 1005 Stroh Building, Detroit 26, Michigan. Railroad accommodations, such as on the Streamliners to Detroit, should be secured at an early date.

Make your plans now to spend these four profitable days in Detroit. If the attendance at the 1947 Conference warrants a continuation of the project, the meeting will be held annually in Detroit.

General Outline

	Wednesday 3/12/47	Thursday 3/13/47	Friday 3/14/47
8:30—9:00 a.m.	Registration Exhibits open	Registration Exhibits open	Registration Exhibits open
9:00—12:00 M.	6 demonstrations or talks	6 demonstrations or talks	6 demonstrations or talks
12:00 M.—2:00 p.m.	Luncheon and speaker	Luncheon and speaker	Luncheon and Speaker
2:00 p.m.—4:20 p.m.	4 talks	4 talks	2:00- Pathological 2:40 "Round-up"
4:20 p.m.—5:00 p.m.	Pathological "Round-up"	Pathological "Round-up"	2:40- 4 Talks 5:00
6:30 p.m.	Conference Dinner and	Dinner hour	End of Conference
8:30 p.m.	Program	Symposium	

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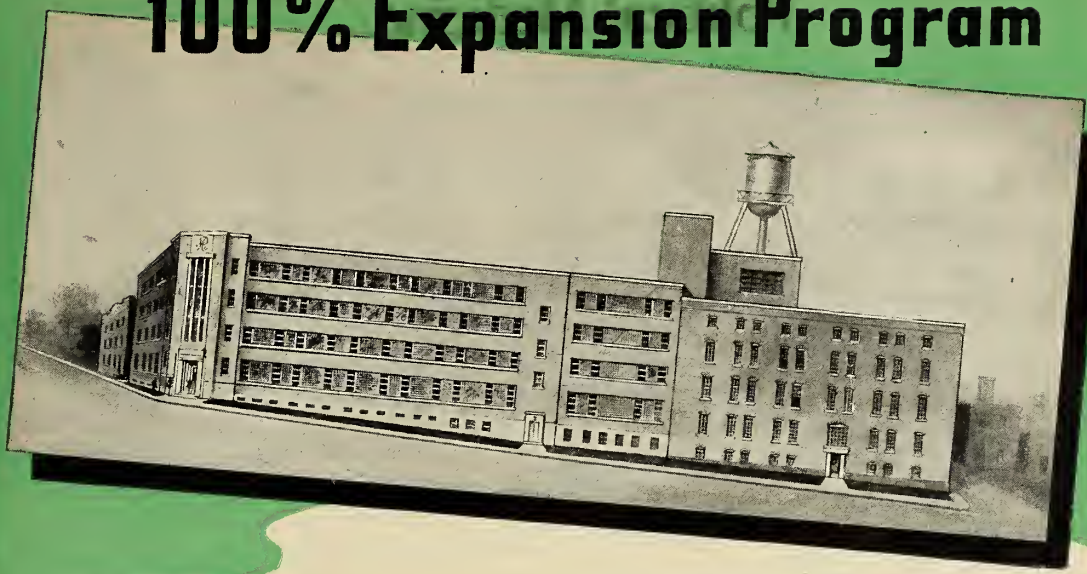

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With a similar expansion underway at the Pitman-Moore Biological Laboratories, we look forward to an ever-broadening program of service to the medical profession.

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Political Medicine

TRADE UNION FOR DOCTORS

Sir:—On the question of the Health Service Bill I consider that action on this matter resolves itself into one of two alternatives: (1) sitting back and hoping for the best from the Government; (2) forming a trade union, which will be in a position to insist on negotiations with the Government and failing a satisfactory settlement will be in a position to organize opposition to the Health Bill. I can see no other practical means by which the medical profession can protect either the public or itself or prevent the Government riding roughshod over it both now or at a future date.

Finally, may I point out that as under the Health Bill we shall lose our independence and become State employes it becomes logical for us to arm ourselves with the only weapon with which the employe has been able to keep in check the employer, namely, the trade union.—L. A. Sylvester, *British Journal,* Nov. 9, 1946.

MUTUAL CONFIDENCE

Sir:—For successful elaboration of the National Health Service Bill the good will of the profession will be essential. This implies mutual confidence. After our recent experience a vote would produce a 99% result of "No confidence" in the present Minister of Health. Bullying and bad faith will wreck any hope of a sound start. The Prime Minister will be wise to appoint a man we can trust and talk to and work with. This is not politics, it is just plain horse sense, for at the best the bulk of the profession views much of this Bill with distrust and misgiving. To us it is an agreed measure.—W. F. Bernsted-Smith, *British Journal,* Nov. 9, 1946.

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The JOURNAL

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Biliary Tract Surgery

A Statistical Study Based Upon 1,070 Consecutive Cases

By Warren W. Babcock, M.D.
Detroit, Michigan

This study which covers the years of 1943 through 1945 was undertaken to determine whether there was any difference between the results obtained at a general hospital, such as Grace Hospital, and those obtained by medical centers throughout the country. In this study, we utilized all cases of biliary surgery regardless of the staff position of the surgeon and regardless of whether the patient was a private or clinic patient.

It was soon noted that although the 1,070 cases of biliary tract surgery were done by eighty-three surgeons, that 608 of these cases (56.8 per cent) were operated upon by only seven surgeons on the staff of our hospital.

Table I shows the breakdown of the 1,070 cases. Note that cholecystectomy (89.4 per cent) comprises by far the largest group of cases operated upon. This is in full agreement with similar studies throughout the country. Our seventy-one cases of cholecystostomy (6.6 per cent), although slightly higher than the general average throughout the country, is still quite good for the diversified group of surgeons represented in the 1,070 operations.

Common bile duct exploration accounted for 162 (15.1 per cent) of all cases. This figure agrees quite well with the averages throughout the country. By common duct exploration, we mean those cases in which the common bile duct was either opened or a diagnostic aspiration of the duct was done. Practically all surgeons record palpating the common bile duct, but this is not considered as true exploration of the common bile duct and is not noted in this report.

Cancer of the biliary system accounted for sixteen cases (1.5 per cent) of all cases operated upon.

Under the heading of "others" we include all operations in which a cholecystectomy or a cholecystostomy was not done at the time of operation.

A glance at Table II shows the types of cases and the results of cholecystectomy. Note that of the 957 cholecystectomies, 159 operations were done for acute cholecystitis (16.6 per cent) and

TABLE I.

Type of Case	*Number*	*Percentage*	*Number Deaths*	*Percentage Deaths*
All cases	1070	100	25	2.33
Cholecystectomy	957	89.4	17	1.7
Cholecystostomy	71	6.6	4	5.6
Common duct exploration	162	15.1	—	—
Cancer	16	1.5	8	50.0
Others	45	4.0	4	8.8

The eight cancer deaths were not included in the total number of deaths.

TABLE II.

Type of Operation	*Number of Cases*	*Deaths*	*Percentage*
Cholecystectomy	957	17	1.7
Acute	159	3	1.9
Chronic	798	10	1.25
Combinations	77	4	5.2

From the Department of Surgery, Grace Hospital, Detroit, Mich. Published simultaneously in the *Grace Hospital Bulletin.*

798 operations (83.4 per cent) for chronic cholecystitis. All these cases listed as acute cholecystitis were cases confirmed by microscopic pathological study. We did not list any case as acute unless we had such microscopic confirmation. Furthermore, this group of acute cholecystitis does not represent the total acute gall-bladder admissions, as some improved under conservative management and were either discharged or later operated upon, with a resultant diagnosis of chronic cholecystitis. In addition, the greater share of the seventy-one cholecystostomies were described by the operating surgeons as acute cholecystitis, but since no sections were made for microscopic confirmation, we did not list this latter group with the acute cholecystitis cases. Under the heading of "combinations" we mean cholecystectomy combined with choledochotomy or choledocholithotomy. In this group, we have seventy-seven cases (8.04 per cent). On a national comparative basis, the total percentage of acute cases (16.6 per cent) is high. The reason for this is that Grace Hospital is a general hospital in a large industrial city and obviously would receive more acute cases than would some of the clinics that have cases sent to them from a considerable distance.

Acute Cholecystitis

In general, we feel that all acute gall bladders should be removed whenever feasible. In those instances in which the technical difficulties incident to removal are great and the general condition of the patient not of the best, we resort to the Gatch operation. This was the procedure of choice in thirty-four cases of acute cholecystitis. There was not a single fatality in this group. We are not afraid of spillage in this type of case as our figures show quite definitely that peritonitis is unusual with this treatment. The work of Gatch,[3] Feinblatt,[2] and Aronsohn and Andrews[11] tends to confirm our observations that in the majority of cases the bile is sterile, and highly suggests that acute cholecystitis may be, initially, chemical in origin. Bile spillage and peritoneal soiling occurred in all thirty-four cases without any peritonitis resulting. In two of the cases, sulfanilamide crystals were used in the peritoneal cavity but of late we have discontinued this practice, as have most centers throughout the country. There were eight cases (0.8 per cent) of ruptured gall bladders. These cases were all very acutely ill, but were well handled surgically and postoperatively. There were no deaths in this group. It is interesting to note that among the cholecystectomies, twenty-eight had been previously operated upon and a cholecystostomy done. Using this number of cases as a percentage ratio, it means that over one-third of all cholecystostomies ultimately will reform stones and require cholecystectomy. To reoperate upon a previous cholecystostomy is often a task of considerable magnitude. This is another argument in favor of eliminating cholecystostomy. There were three deaths in this reoperated group.

The surgical treatment employed in these acute cholecystitis cases is as follows: If there is too much edema and the various layers of the gall bladder will not separate, giving the surgeon a dissecting plane, either the gall bladder must be evulsed from its bed or a Gatch operation performed. In the Gatch operation, we are not afraid of spillage. The gall bladder is aspirated first if desired. Then the gall bladder is cut through, leaving a ¼ to ½ inch fringe of all layers attached to the liver. One need not worry about severing the cystic artery. Sometimes it bleeds, and sometimes the edema present is so great that it is already thrombosed. If the artery does bleed, it is fixed in a thick edematous gall-bladder wall and is easily secured. The remnant of mucosa left on the portion of the gall bladder attached to the liver is treated in various fashions. At times, it is so necrotic and loosely adherent that it can easily be wiped out with gauze. At other times, it can readily be removed by sharp dissection. Occasionally it is very adherent. In these latter cases, a small bone curet is used to curet out the mucous membrane, and then two applications of phenol are applied and each application is followed with alcohol. Finally, the remnant attached to the liver, now minus its mucosa, is sewed over a very small catheter. It does not matter whether the cystic duct is tied or not. If the cystic duct is edematous, it should not be tied. In those cases in which the cystic duct is tied and it is not necessary to use phenol in the removal of the attached mucosa, a catheter is not necessary. In this type of case, we merely approximate the cut gall-bladder edges. Dr. Gatch, who developed this particular type of mucoliasis operation, usually ties the cystic duct. Waltman Walters,[4] on the other hand, does not tie the cystic duct. All the patients treated in this way showed a surprisingly smooth convalescence.

Chronic Cholecystitis

In this group of 957 cholecystectomies, 798, by far the largest number, (83.4 per cent) were operated upon for chronic cholecystitis or cholelithiasis. In this group of chronic cholecystitis cases, there were forty-six non-calculus gall bladders (4.8 per cent). The number of cases in which non-calculus gall bladders were removed is much too high. Some of these forty-six cases had their gall bladders removed in spite of a normal cholecystogram. Many of these cases had no x-rays at all, but cholecystectomy was done because it was noted during an operation for other pathologic conditions that, "the gall bladder was very tense and hard and bluish in color." Since the color of the normal distended gall bladder is bluish, and gall-bladder bile in its normal state is always thicker and darker than common duct bile, and since normal gall bladders are usually hard and tense at operation due to spasm of the sphincter of Oddi as a result of stimulation from anesthesia, it becomes very difficult to know why these gall bladders were removed. One of these cases was a twenty-year-old woman. The pathological report in her case was "chronic cholecystitis, very mild." The "very mild" was underlined. Some surgeons use "adhesions around the gall bladder" as a reason for its removal. We feel that it is a rare case where adhesions are dense enough to truly restrict gall-bladder function. Adhesions around the neck of the gall bladder and in the region of Hartmann's pouch are so common as to be almost the rule rather than the exception. One surgeon found a very tense gall bladder at operation. Because it was impossible to palpate any calculi in this type of gall bladder, he collapsed it by aspirating the bile. He examined the bile and found it to be normal. Palpation of the gall bladder in its collapsed state proved it to be empty. This surgeon then closed the paracentesis opening with a purse-string suture and closed the abdomen after removing the appendix. This surgeon's admission and operative diagnosis was "acute cholecystitis." He admitted his error in his operative dictation. We wonder how many of the forty-six non-calculus gall bladders that were removed, were removed because the preoperative diagnosis was gall-bladder disease. It takes intestinal fortitude to explain to a patient that you were wrong.

Cholecystostomy

There were seventy-one cholecystostomies in this series, a percentage of 6.6 per cent. We feel that this is too high, although it is only slightly higher than the general average throughout the country. The mortality rate for cholecystostomy, 5.6 per cent in our series, is more than twice as high as the mortality rate for cholecystectomy. We feel that cholecystostomy should be reserved for cases of carcinoma with obstruction of the common duct or to a very occasional isolated case in which the patient's condition is so bad that no other procedure is feasible. In such cases, it is always better to use a soft rubber drain rather than a hard tube drain. Two of the cases of peritonitis and death in our series were due to large tube drainage cholecystostomy. Fully one third of all cholecystostomies eventually return for cholecystectomy because of calculus formation. Reoperation in such cases is indeed a formidable procedure. There were twenty-eight such cases with three deaths (10.7 per cent).

Common Duct Exploration

Common duct exploration was performed in 162 cases (15.1 per cent). The three main indications for opening a common duct were (1) jaundice, (2) dilated common duct, (3) palpable stones within the common duct. Several operative records mention dilated common ducts but do not mention aspiration or opening of the common bile duct. We feel certain that because of this neglect several small ampullar calculi could easily be missed. In case of doubt, it is always better to aspirate the common bile duct using a 10-c.c. syringe and a 21-gauge needle. If the aspirated bile is clear and golden yellow, then the duct need not be opened. If, however, the bile is flocculent, thick or greenish, and contains small particles of material, it should be opened and probed. It is always a good practice to aspirate the common bile duct before opening it, as occasionally the portal vein lies on top of the common duct and looks exactly like it. Cutting into the portal vein is apt to be disastrous for the patient. Eight patients (7.6 per cent) had choledocholithotomy alone done. This group represents previous surgical error. All these cases had had a previous cholecystectotomy or choledochotomy and cholecystectomy but common duct stones were missed at the first operation. All these reoperated cases were technically very difficult.

TABLE III. OTHERS

Operation	*Number of Cases*
Cholecystojejunostomy	6
Biopsy of the liver	5
Choledochoduodenostomy	4
Reconstruction or repair of common bile duct	4
Removal of catheter from the common duct via the duodenum	1
Removal of sinus tract and gall bladder	1
Repair of cholecystocolonic fistula	1
Repair of cholecystogastric fistula	1

One can never be sure that there are no stones in the common duct or in the ampulla of Vater unless the common duct is opened and carefully probed. Three surgeons reported injuring the common bile duct during cholecystectomy. These men recognized the accident and made the proper repairs and so reported it in their operative dictation. We all have accidents, but do we all recognize them, correct them, and then record the truth in so doing? None of these cases died. These three accidents out of 1,070 operations, an incidence of 0.28 per cent, give one an idea of the frequency of such an accident in a general hospital.

Cancer of Biliary Tract

There were sixteen cases of cancer of the biliary tract. This is an incidence of 1.5 per cent. Our results in this type of case are poor. A 50 per cent mortality rate speaks for itself.

"Others"

Table III outlines the various operative procedures classified as "others." Note the six cholecystojejunostomies. These were done in three cases of carcinoma of the head of the pancreas with common duct obstruction, and in three cases for stricture of the common duct. Three of these patients died before hospital discharge, and the remaining three had recurring attacks of chills, fever, and malaise. From this experience, we can only conclude that, if it is at all possible, choledochoduodenostomy should be the operation of choice in such cases.

Aside from these statistical grounds, we feel that choledochoduodenostomy is the operation of choice for the following physiological reasons:

1. The intestinal contents of the duodenum are more sterile than the contents of the jejunum.
2. There is a more direct route for the bile to pass from the liver into the intestinal tract.
3. Any drag or pull from the small bowel is eliminated with duodenal anastomosis.
4. Some authorities ascribe a sucking or vacuum action in the duodenum that would tend to prevent an ascending cholangitis.

As proof of the soundness of these physiological reasons, four choledochoduodenostomies were performed. All but one of these made an uneventful recovery.

In this group also was one case in which a sinus tract from a previous cholecystostomy had never stopped draining. The sinus tract and gall bladder were both removed at this operation. Recovery was uneventful.

Drainage

The problem of gall-bladder drainage is still unsettled. "To drain or not to drain: that is the question" is more suggestive of Shakespeare than surgery. From our analysis, there appears to be an increasing tendency on the part of some men not to drain. One of the "simple cholecystectomies" that was not drained, re-entered the hospital approximately two weeks after his original discharge with a diagnosis of acute intestinal obstruction from which he died. At the original operation the abdominal examination showed no pathologic condition. The microscopic diagnosis of the gall bladder was chronic cholecystitis—no stones. We are strongly inclined to the belief that all cholecystectomies should be drained. Ideally, a Penrose drain without gauze should be brought out from a stab wound. We leave drains in until the dressings show no signs of blood, serum, or bile. This usually takes two to three days. If much drainage persists, then the drain should not be removed until a sinus tract is established. This ordinarily takes eight days. Some surgeons are in the habit of removing one inch of the drain daily. This gives the added advantage of daily inspection of the dressing and closure of the sinus from within, out. In one case, the drain was removed too soon. Bile peritonitis developed. The surgeon recognized this immediately, reoperated upon the patient, putting in a new drain. The patient recovered. One patient had a T-tube placed in the common bile duct but no Penrose drain, and developed both subphrenic and lung abscesses during a ninety-nine-day postoperative stay.

TABLE IV. EVISCERATIONS AND WOUND DISRUPTIONS

	Number of Cases	*Per Cent*	*Evisceration Disruption*	*Per Cent*
Cholecystostomy	71	6.6	6	8.4
Right rectus incision	695	65.0	18	2.6
Transverse incision	375	35.0	2	0.5

TABLE V. CAUSE OF DEATHS

Cause	*Number*	*Percentage*
Cardiovascular disease	7	28
Liver deaths	7	28
Peritonitis	4	16
Pulmonary embolus	2	8
Atelectasis	1	4
Biliary fistula	1	4
Gastric fistula	1	4
Duodenal fistula	1	4
Pneumonia	1	4
Total	25 cases	

Time—Preoperative, Operative, and Postoperative

Our average preoperative stay in the hospital was 3.2 days. This gives the surgeon time to study and prepare the patient adequately for surgery. Twenty-five per cent of all the cases operated upon had no preoperative study at all, and one case in which there was a preoperative stay of twenty-four days exemplifies needless "dilly-dallying."

Operative time does not mean too much in gall-bladder surgery. The shortest operative time for cholecystectomy was twenty minutes and the longest for a complicated choledochoduodenostomy was five hours. Both patients recovered. It appears quite evident from our study that it is not speed of an operation that determines morbidity but rather the gentleness with which tissues are handled and the care exercised in the performance of the operation. In general, hasty rough gall-bladder surgery is followed by more complications than deliberate careful surgery.

Postoperatively, our average patient's stay of fourteen days was considered good. Some patients were discharged in five to seven days using the "early ambulation" technique. One case, carcinoma of the biliary tract, remained in the hospital seven months until she died.

Eviscerations and Wound Disruptions

This study of eviscerations and wound disruptions was quite informative. Under right rectus incisions were grouped the right paramedian, Mayo-Robson, hockey-stick, and right rectus incisions. The traverse incisions include the Deaver, Kocher, subcostal, and the true transverse. The incidence of transverse incisions is increasing each year. We feel that this is for the best. Most of us, however, still revert to the right rectus incision when we feel that there are complications present. A study of Table IV shows that there were five times as many eviscerations and disruptions in terms of percentages in the right rectus incisions as compared to the transverse incision. The right rectus cases, however, were on the average somewhat poorer risks. Similarly, there were sixteen times as many disruptions and eviscerations in the cholecystostomies as in the transverse incision cases. All but two of the seventy-one cholecystostomies were right rectus incisions. Neither of the two transverse incision cholecystostomies disrupted. One case that developed a duodenal fistula was closed with wire, but in spite of this, the wound disrupted and the patient eviscerated. A second case operated upon for rupture of the gall bladder was drained by a stab wound in the right flank, and the incision (right paramedian) was closed by through-and-through wire. This wound was carefully closed with interrupted wire through fascia and peritoneum and tied with a square knot. The skin was closed with interrupted black silk, thus burying the wire knots. The wound disrupted. At the time of secondary repair, it was noted that four of the eight wire sutures had become untied and the rest had pulled through the fascia. We cannot help but feel that if the tissues are infected, the abdomen distended, and the patient in poor nutritional condition, that evisceration is apt to occur regardless of the type of closure.

Table V shows that of the causes of death in biliary surgery, the unquestionable leader is cardiovascular accidents. We know of no method of improving the figures in this group except perhaps by urging greater care in the preoperative study of patients coming to operation, specifically with regard to the heart. Possibly, an electrocardiograph should be insisted upon in all patients over the age of forty who are to have biliary surgery. Of the seven cardiovascular fatalities, four were due to coronary occlusion. Of these four, three were "bed pan" deaths. The sitting on a bed pan in an

uncomfortable position with flexion at the thighs and straining apparently brought these occlusions on. One fatality was due to a ruptured cerebral aneurysm and the remaining two were due to acute cardiac dilatation. One of the coronary accidents occurred on the ninth postoperative day, while the patient was getting in a wheel chair. At operation, this patient had no gallstones and the pathological report of the gall bladder was chronic cholecystitis.

The seven reported liver deaths were somewhat misleading. We used this term to include a heterogenous group of cases. Three cases were omentopexy for advanced portal cirrhosis and ascites. Two others were cases of advanced cirrhosis of the liver in which liver biopsies were taken and the abdomen closed. The remaining two liver deaths were true hepatic failures. One of the two was signed out as "bile peritonitis," but as there was no excessive bile drainage on the dressing, and as death rapidly occurred in slightly less than three days with a typical picture of liver shock with no other complications, we took the liberty of tabulating this as "liver death."

In two other instances, the operating surgeons grossly described and diagnosed a cirrhosis of the liver in their operative dictation. Sections were taken of the liver. In both cases, the pathological reports were carcinoma of the liver. This type of biopsy is to be encouraged.

Although peritonitis ranked third as a cause of death in this study, it does not seem to be a major consideration in biliary tract surgery. Two of the peritonitis cases were cholecystostomies with large tube drainage through the operative incision. The third peritonitis death was a cholecystectomy and choledocholithotomy. This patient developed a subdiaphragmatic abscess and lived forty-two days postoperatively. The last patient developed peritonitis following cholecystectomy for chronic cholecystitis. All these patients developed peritonitis and died before the advent of penicillin. It would be of interest to note any change in these figures since the use of penicillin has been popularized. Of the 159 cases of acute cholecystitis including ruptured gall bladders, there was no single case of generalized peritonitis.

It is quite possible that, with the use of "early ambulation" in selected cases, the one pneumonia and the two pulmonary embolism deaths might have been avoided. This would improve the mortality statistics somewhat.

The biliary fistula case was a woman of seventy with many large common duct stones. Operation was mandatory and the fatality probably unavoidable.

The gastric fistula was signed out as bile peritonitis. This appears to be a popular diagnosis in that it covers a multitude of sins. In no instance in our twenty-five fatalities could we find a single example of true bile peritonitis. In this particular case, the nurse's notes describe a fetid brownish fluid as continually pouring out of a broken-down operative wound. The surgeon, in his operative dictation, describes a repair for an opening into the stomach due to a cholecystogastric fistula.

The duodenal fistula case was closed with wire, but the patient developed an evisceration and died.

Summary

From the statistical studies we have made, we have tried to set up an ideal cholecystectomy. In this ideal case, the patient would be properly prepared and studied by a preoperative stay in the hospital of approximately three days. At the same time vitamins, proteins, and glucose would be given, along with the proper evaluating studies. A transverse incision would be made. On opening the abdomen a careful survey of the stomach and other abdominal organs would be made, and an appendectomy performed if possible. The intestines would be packed away from the gall bladder, packing medially first and then inferiorly. The common bile duct is then palpated or aspirated to rule out common duct pathologic processes. If a pathologic condition is present, one may want to preserve the gall bladder. The cystic duct and artery are separated. The cystic artery should be ligated first because it is the shortest of the two structures as well as the most dangerous. If the cystic duct is tied and cut first, and then traction is applied to the gall bladder, the artery is apt to be torn at its junction with the hepatic artery. Next the duct is tied and cut. A cuff is now made around the gall bladder ¼ to ½ inch from the liver margin. One should remember that on the liver side the gall bladder has but three tissue layers, while on the side facing the abdomen there are four layers. Thus if the peritoneum alone is reflected to the liver margin, and the gall bladder is removed from its bed, not much more has been accomplished than if no peritoneal cuff had been left at all. To secure a firm fascial bed attached to the liver that will not bleed,

dissection must be made between the fibromuscularis and the subserosal layers. There will be little, if any, bleeding, if the dissection is confined to this plane. It does not matter whether or not the gall bladder is removed from below up or above down. Whichever appears easiest under the circumstances should be done. After the gall bladder has been removed, we suture this flap together. We feel that the raw inner edges of the flaps, as well as the unprotected gall-bladder fossa itself, are conducive to adhesions. By not closing the flaps, surgeons make possible seepage and bile oozing. Abdominal closure is made using one soft rubber Penrose drain down to the operative area. The drain is brought out through a stab wound.

Conclusions

1. Cholecystostomy has the highest morbidity and mortality.
2. Known coronary heart disease in combination with gall-bladder surgery offers a poor prognosis.
3. Peritonitis is not a serious consideration in biliary tract surgery.
4. A small percentage of cholecystectomies are being performed without sufficient pathological justification.
5. In acute cholecystitis, the Gatch type of cholecystectomy appears to give the best results.
6. Our results with cholecystojejunostomy were poor.
7. Transverse incisions seems to be best for all types of biliary surgery from the standpoint of morbidity and wound disruption.
8. In biliary tract surgery, the local use of sulfanilamide did not appear to be of much value.
9. Approximately one-third of all cholecystostomies will reform stones and require a second operation.
10. Cholecystectomies in which no regard is taken of the fascial planes have a higher morbidity than those in which the dissection is in the fibromuscularis plane, leaving a cuff which is sutured.
11. Remove common duct stones before removing the gall bladder.
12. Skin retention sutures or the use of through-and-through wire does not prevent eviscerations. They will cut and strangulate the intestines in the event of such evisceration.

(Continued on Page 84)

A Clinical Study of 180 Cases of Arthritis

The Use of Steroid Complex (Whittier), Orthopedic and Other Supportive Measures in Chronic Arthritis

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THIS REPORT DEALS with a total of 180 chronic arthritic patients treated and followed jointly by the Special Arthritis Clinic and the Department of Bone and Joint Surgery, Northwestern University, during the past four years. This total is composed of two groups:

1. One hundred fifty-eight patients ranging in age from twenty-two to eighty-two years, in whom therapy was primarily medical, with adjunctive use of orthopedic measures.
2. Twenty-two patients ranging from twelve to sixty-four years, with more severe, chronic, active, rheumatoid arthritis, in whom medical management was primarily directed at preparation for subsequent orthopedic surgery.

Selection of Patients

Patients were referred from the general clinic pool. Economically, they were of low-income levels, but adequate diet and housing were available to all of them. Following a thorough physical examination, they were admitted to the Special Arthritis Clinic, where they were examined by members of the Bone and Joint Department for purposes of classification into one of the following types:

1. Atrophic
2. Hypertrophic
3. Marie-Strumpell
4. Traumatic
5. Mixed.

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Dr. Magnuson, professor of bone and joint surgery, and Dr. McElvenny, assistant professor of bone and joint surgery, are in the Department of Orthopedics while Dr. Logan is instructor in the Department of Medicine, the Medical School, Northwestern University.
The Whittier steroid complex is also called Ertron.

TABLE I. CASE TOTALS

Group 1. Diagnosis	Cases
Atrophic	36
Hypertrophic	39
Marie-Strumpell	4
Traumatic	3
Mixed	76
Total	158
Group 2. Diagnosis	**Cases**
Atrophic—Severe, chronic, active rheumatoid arthritis	22
Total—Groups 1 and 2	180

The number of patients in each type is listed (Table I).

Excluded were patients with the following conditions frequently found to have been classed and treated as arthritis: periarticular fibrositis of the shoulder (so-called "frozen shoulder"); tenosynovitis of various types such as stenosing, tubercular, and "trigger finger"; gout; syphilis; scalenus syndromes; osteochondritis of joints; malum coxae senilis; tuberculosis of joints; decompensated feet and backs; postural and other occupational strains; ruptured intervertebral discs; hallux rigidus and non-extensus.

On admission to the Special Arthritis Clinic, complete blood count and differential, sedimentation rate, urinalysis, and blood chemistry including calcium, uric acid, nonprotein nitrogen and phosphorus determinations were made on each patient. These tests were repeated at least every six months or oftener when indicated. Serial x-rays and independent orthopedic examinations, without reference to previous findings, were conducted at similar intervals.

No patient with a major illness other than arthritis was included in this study because treatment would demand concessions from the program adopted for arthritis.

Management

Because of the differences in patients affected with the various types of arthritis and their therapeutic needs, both medical and orthopedic services were offered.

In Group 1, in which therapy was primarily medical and in which no major orthopedic surgery was contemplated, orthopedic appliances and physical medicine were employed in association with the use of medication (Table II).

In Group 2, presenting more severe, chronic, active, rheumatoid arthritis, unresponsive to previous therapy, treatment was confined to medication alone as preparation for subsequent orthopedic surgery. Rheumatoid arthritis is recognized as a generalized, systemic disorder involving all body tissues, with atrophic joints as only one of its local manifestations. Therefore, surgical correction of deformities subsequent to arrest or stabilization of

TABLE II. GROUP 1. ADJUVANT THERAPY USED IN FORTY-SIX PATIENTS

Patient	Type of Arthritis	Degree of Improvement
	Physiotherapy*	
I. D.	H	0
M. B.	H	3
L. F.	M	2
M. G.	A	1
A. H.	M	1
D. H.	M	2
C. K.	M	4
M. L.	A	4
R. Mc.	M	2
H. McM.	M	0
M. P.	M	4
L. R.	M	3
M. S.	M	1
G. S.	A	2
F. S.	A	4
B. S.	M	4
E. S.	H	1
R. W.	M	3
A. Y.	M	0
R. Z.	H	1
R. A. F.	T	2
K. H.	H	2
L. K.	H	4
G. L.	A	3
J. M.	H	3
B. S. A.	M	3
J. S.	M	0
I. S.	M-S	0
H. W. T.	T	2
E. V.	M	1
	Orthopedic	
R. S.	A	2 Shoes
A. G.	A	1 Body cast
C. H.	M	3 Surgery, feet
M. H.	H	5 Body cast
R. H.	M	4 Surgery, feet—shoes
F. R.	M	2 Sacroiliac corset
A. S.	M	3 Body cast and shoes
G. T.	M	1 Corset
C. S.	M	3 Body cast and sacroiliac belt
	Both	
W. G.	H	2 Corset
M. H.	M	4 Hospital
R. L.	M	4 Surgery, feet—shoes
W. McN.	M	4 Body cast
E. M.	M	3 Body cast, corset
G. R.	M-S	4 Shoes
B. S.	M	3 Shoes

*Does not include use of paraffin baths or fracture boards.

SUMMARY OF TABLE II.

Type of Case	Number of Cases	Type of Treatment	Number of Cases
Hypertrophic (H)	9	Physiotherapy	30
Atrophic (A)	7		
Mixed (M)	26	Orthopedic	9
Marie-Strumpell (M-S)	2		
Traumatic (T)	2	Both	7
Totals	46		46

TABLE III. GROUP 1. RESULTS OF THERAPY. PERCENTAGE OF PATIENTS OF EACH TYPE AND DEGREE OF IMPROVEMENT

Atrophic	Hypertrophic	Mixed	Marie-Strumpell	Traumatic	Total Series
0— 5.6% (2)	0—12.8% (5)	0— 6.6% (5)	0—25% (1)		0— 8.2% (13)
1— 8.3% (3)	1— 7.7% (3)	1— 6.6% (5)	1—25% (1)		1— 7.6% (12)
2—22.2% (8)	2—20.5% (8)	2—19.7% (15)	2—25% (1)	2—66.6% (2)	2—21.5% (34)
3—22.2% (8)	3—33.3% (13)	3—35.5% (27)			3—30.4% (48)
4—33.3% (12)	4—17.9% (7)	4—27.6% (21)	4—25% (1)	4—33.3% (1)	4—26.6% (42)
5— 8.3% (3)	5— 7.7% (3)	5—3.9 % (3)			5— 5.7% (9)
Total Patients—36	39	76	4	3	158

the local pathologic process may be followed by a protracted period of adequate function. It is realized that orthopedic management can also offer prevention of deformities by immobilization or fusion of joints, traction and support aimed at local rest, followed or accompanied by the procedures of physical medicine.

Medication employed in each of the patients in this study was electrically activated heat-vaporized ergesterol.*

The preparation was administered in capsules, each containing 5 mg. of activation products with an antirachitic activity of 50,000 U.S.P. units. The daily dose in most instances was 30 mg. (six capsules). Three glasses of milk daily were included in the diet to provide a normal calcium intake.

Criteria Used for Evaluation of Results

In evaluating the results of therapy, each patient was personally questioned and his case history and treatment record reviewed. His status at the conclusion of the observation period as compared with that at the beginning of the observation period was then evaluated according to the following criteria:

0—No improvement.

1—General improvement: more energy and strength, less easy fatigability, subjective.

2—Less pain and swelling of joints.

3—Less pain and swelling with increased motion.

4—Marked improvement: only occasional pain, markedly increased motion, systemic improvement.

5—Symptom-free.

Results of Therapy

Group 1.—In this group of 158 patients, the average length of treatment was 7.8 months—with a maximum period of twenty-nine months.

As indicated in Table III, in 91.8 per cent of the cases improvement of some degree was evidenced while complete failure occurred in 8.2 per cent. Patients classified under criteria 4 and 5 (marked improvement or symptom-free) made up 32.3 per cent of the entire group. According to the types listed in Table I, 41.6 per cent were of the atrophic type, 25.6 per cent were of the hypertrophic type, and 31.5 per cent were of the mixed type.

Group 2.—In this group of patients, the average length of treatment was 24.8 months with a minimum period of nine months and a maximum period of forty-six months.

Inasmuch as all of the patients in this group with severe, chronic, active, rheumatoid arthritis had been selected for eventual orthopedic surgery, the results of therapy were evaluated from this standpoint. Unless improvement under medical management was striking (criteria 4 and 5) with definite diminution of joint swelling and increase in range of painless joint motion, treatment was not considered as successful. In the favorable cases, gain in weight, a feeling of well-being, increase in endurance and ability to perform work were common findings.

On the above basis of evaluation, fourteen of the twenty-two cases (63.6 per cent) were considered as presenting favorable results while eight of the cases (36.3 per cent) were classed as unsuccessful.

Of interest may be the following findings in the patients in this group. No demonstrable changes in the joint structures themselves were revealed by x-ray except in the favorable cases where a decrease in size of soft tissue fusiform shadows surrounding small joints was observed. No decrease in amount of crepitus in knee joints was observed, although the swelling in favorable cases had decreased or disappeared and the range of painless motion had increased. In the shoulder joints, de-

*This product, prepared by the Whittier process, is described as a steroid complex containing a number of hitherto unrecognized factors which are members of the steroid group. Although it possesses antirachitic activity, only 30 per cent of this has been accounted for on the basis of its calciferol content. Moreover, the presence of toxisterol, tachysterol, lumisterol or the suprasterols—products also formed during the ultraviolet irradiation of ergosterol—has not been demonstrated.

TABLE IV. SYMPTOMS OF INTOLERANCE CORRELATED WITH NONPROTEIN NITROGEN AND CALCIUM BLOOD LEVELS

Patient	Symptom	Nonprotein Nitrogen	Calcium
E. M.	Anorexia	35.0	10.4
		37.5	11.1
		25.8	11.1
L. F.	Anorexia	30.8	10.2
		33.5	10.0
		35.5	9.7
W. V.	Anorexia	43.3	10.1
R. W.	Anorexia (nausea at times)		
I. D.	Nausea	38.9	10.9
J. B.	Nausea	29.0	9.0
		36.7	9.7
		35.0	10.0
C. H.	Nausea (slight)	43.0	10.6
		38.2	11.2
		42.8	10.0
R. H.	Nausea (slight)	36.4	—
	Constipation	44.6	9.5
	Nocturia		
	Frequency		
A. H.	Nausea	33.3	9.5
	Diarrhea	43.6	9.9
W. McN.	Nausea	32.4	9.4
	Heart burn	37.8	10.4
B. R.	Nausea	35.8	9.5
		25.1	9.7
R. Z.	Nausea (slight)	27.2	9.55
		33.5	9.4
		34.0	10.1
R. F.	Nausea	38.0	9.3
		40.1	11.1
J. S.	Nausea	35.5	9.6
A. J.	Heart burn	32.5	9.1
N. L.	Constipation	27.0	9.6
		29.7	10.3
R. McC.	Constipation	33.3	10.8
		34.0	10.2
		34.8	9.3
F. A.	Nocturia	32.0	9.5
		35.8	10.3
H. D.	Nocturia	32.3	9.0
A. G.	Nocturia	44.0	10.7
	Frequency	41.8	9.63
		42.3	—
M. H.	Nocturia	30.1	9.8
		43.5	11.3
		40.2	11.6
N. G.	Nocturia	34.2	9.4
I. S.	Nocturia	—	10.4
		39.8	—
E. V.	Nocturia	38.9	10.0
M. K.	Nocturia	39.5	10.3
		34.3	11.3
S. W.	Anorexia	33.5	10.0
	Nausea	35.5	9.0
	Vomiting	—	10.4

Total Number of Patients with Symptoms of Intolerance—26
Incidence—14.4%

crease in crepitus accompanied increase in joint motion and function.

In the favorable cases, the function of small joints, particularly of the metacarpo-phalangeal and phalangeal joints, was evidenced by decrease in swelling and pain, allowing complete functional closure of both hands. Degree of existing bony deformity of these joints was not affected by treatment. In three cases, flexion deformities of elbows and knees were lessened and in one case completely disappeared.

Tolerance to Medication

At every visit, each patient in the entire series of 180 patients was questioned closely for evidence of intolerance or toxic reaction to the medication used. At the first appearance of anorexia, constipation, nausea, headache, frequency of urination or nocturia, medication was withheld until all symptoms had disappeared. Then it was resumed in smaller dosage and gradually increased. It was observed, as by Reed,[3] that there is often a sudden adjustment of tolerance after an initial period of intolerance.

Twenty-six patients (14.4 per cent) evidenced intolerance at some time. In some of these cases the intolerance was so slight that it was not necessary to stop the medication. However, in one patient who had severe gastric disturbance with oral administration of the medication, no symptoms of intolerance recurred with its parenteral administration. The symptoms of intolerance, correlated with nonprotein nitrogen and calcium blood levels, are listed in Table IV.

The patients were instructed to drink three glasses of milk daily while on the medication used. This is accepted as providing a normal calcium intake and is administered in order to prevent toxic symptoms. Reed[3] has shown that any increase over normal calcium intake predisposes the patient to intoxication; for this reason, additional calcium salts should be avoided.

Reynolds studies[4] indicate that electrically activated heat-vaporized ergesterol contains chiefly nontoxic factors in contrast with the ultraviolet irradiated products which contain the toxic products, tachysterol and toxisterol. This would explain the almost complete absence of significant increase in the blood calcium, since calciferol is not hypercalcemic, according to Correll and Wise,[1] unless excessive doses (1,000 times minimal) are employed. In this entire series only two cases showed variation in calcium levels while under treatment.

Some of the patients exhibiting symptoms of intolerance objected to having the medication withdrawn because they felt that their improvement more than balanced any disturbances that occurred. This was especially true of those patients with the urinary complaints of frequency and nocturia.

In twenty-five patients who were found to have a rise in nonprotein nitrogen above an initially normal level while on therapy, the average increase was only 7.5 mg. per 100 c.c. The maximum elevation was from 38 mg. to 53.1 mg. per 100 c.c.; in a few weeks, however, this had again dropped to 46.9 mg., even though therapy was continued.

The evidence is very slight for a relationship between toxic manifestations and changes in kidney function, at least insofar as retention of nitrogenous products is concerned. Many of the patients who originally had some elevation of the nonprotein nitrogen were found later to have normal values.

In considering the results of repeated determinations of the nonprotein nitrogen before and during treatment, no correlation could be found between any changes, either elevation or decrease, with clinical improvement or with evidence of intoxication. Of the twelve patients who showed initially high nonprotein nitrogen values, six maintained the elevation under therapy whereas the other six showed a decrease.

It was of interest to find a high incidence of uric acidemia in arthritic patients. As suggested by

TABLE V. FOLLOW-UP OF IMPROVED PATIENTS (CRITERIA 4 AND 5)

Patient	Status When Last Seen	Duration of Therapy	Length of Time off Therapy	Status at End of Observation Period
Atrophic				
L. K.	5	4 mo.	7 mo.	Maintaining status; to be rechecked in 6 mo.
T. R.	5	6 mo.	12 mo.	Working full time in restaurant. Occasional pain after carrying heavy trays.
I. V.	5	9 mo.	12 mo.	Unable to contact.
C. D.	4	7 mo.	16 mo.	Unable to contact.
F. B.	4	7 mo.	—	Active at clinic.
C. G.	4	3 mo.	17 mo.	Unable to contact.
L. L.	4	5 mo.	17 mo.	Unable to contact.
M. L.	4	5 mo.	—	Active at clinic.
C. L.	4	8 mo.	—	Active at clinic.
A. M.	4	7 mo.	—	Active at clinic.
F. S.	4	19 mo.	—	Active at clinic.
A. S.	4	6 mo.	12 mo.	Unable to contact.
J. T.	4	23 mo.	—	Active at clinic.
A. J.	4	7 mo.	—	Active at clinic.
M. L. W.	4	3 mo.	—	Active at clinic.
		Av. 7.93 mo.		
Hypertrophic				
M. H.	5	8 mo.	6 mo.	Has maintained 75% improvement.
L. S.	5	11 mo.	12 mo.	Continued relief of joint symptoms.
F. W.	5	4 mo.	19 mo.	100% improvement.
A. F.	4	7 mo.	22 mo.	Unable to contact.
C. H.	4	29 mo.	—	Active at clinic.
L. L.	4	3 mo.	18 mo.	Unable to contact.
E. S.	4	3 mo.	19 mo.	Expired, May, 1945.
L. K.	4	3 mo.	—	Active at clinic.
A. M.	4	3 mo.	—	Active at clinic.
L. M.	4	4 mo.	—	Active at clinic.
		Av. 7.8 mo.		
Mixed				
C. D.	5	9 mo.	10 mo.	Unable to contact.
M. F.	5	5 mo.	19 mo.	Confined to home because of cardiac condition. Joints worse this winter.
M. J.	5	7 mo.	13 mo.	Has maintained 100% improvement.
A. D.	4	6 mo.	12 mo.	Has maintained improvement. Boards street cars readily.
E. B.	4	10 mo.	—	Active at clinic.
F. G.	4	3 mo.	24 mo.	Working full time as painter. Previous to Ertron, had not worked for 3 mo. No pain.
M. H.	4	26 mo.	—	Active at clinic
R. H.	4	17 mo.	—	Active at clinic.
C. K.	4	11 mo.	—	Active at clinic.
M. K.	4	9 mo.	6 mo.	Practically symptom-free. Working full time as bank clerk. Better than in years.
R. L.	4	8 mo.	—	Active at clinic.
E. L.	4	8 mo.	—	Active at clinic.
J. M.	4	12 mo.	—	Active at clinic.
E. McG.	4	3 mo.	14 mo.	Condition very good. Working.
W. McN.	4	11 mo.	9 mo.	Unable to contact.
D. M.	4	5 mo.	23 mo.	Has maintained 75% improvement. Some aching of soft tissues in wet weather.
M. P.	4	3 mo.	21 mo.	Unable to contact.
B. R.	4	7 mo.	—	Active at clinic.
L. S.	4	6 mo.	1 mo.	Died of heart disease: aged 82 years.
L. S.	4	6 mo.	16 mo.	Doing all her own work.
B. S.	4	18 mo.	—	Active at clinic.
R. W.	4	21 mo.	—	Active at clinic.
P. C.	4	3 mo.	—	Active at clinic.
N. G.	4	5 mo.	—	Active at clinic.
		Av. 9 mo.		
Marie-Strumpell				
G. R.	4	7 mo.	—	Active at clinic.
Traumatic				
J. B.	4	14 mo.	—	Active at clinic.

Magnuson,[2] any value above 3.5 mg. per 100 c.c. is accepted as a definite increase over normal. In this series, 12.2 per cent (twenty-two) showed an elevation on admittance, and in 11.1 per cent (twenty) the uric acid rose from a normal during treatment on an average of approximately 1.38 mg. Of these, four subsequently returned to normal. Some were given a low-purine diet simultaneously with this form of therapy; others were maintained on a normal general diet. On repeated tests no correlation could be found between clinical improvement and the blood uric acid level.

Maintenance of Improvement Following Cessation of Therapy

In Group 1, the fifty-one patients who showed marked improvement or became symptom-free (under criteria 4 and 5 in Table III) are listed again in Table V. In the follow-up of these patients, at the close of the observation period, the nine patients who had been dismissed symptom-free, with medication discontinued, together with sixteen other patients who had shown this degree of improvement but who were no longer attending the clinic, were called in so that an evaluation might be made of the degree of improvement maintained after cessation of treatment.

The status of these patients is also given in Table V. The average treatment period for those dismissed as symptom-free was seven months. These patients experienced no return of their symptoms for an average of twelve months although they received no treatment of any kind and had been carrying on their normal routine of work. In Group 2, as indicated above, treatment was maintained for longer periods.

Conclusions

From this study of 180 proved arthritics, a large percentage of whom had previously received many types of therapy without benefit, the following conclusions can be drawn:

1. Although the steroid complex used is not a specific therapeutic agent for the treatment of rheumatoid arthritis, the highest percentage of patients in this series made symptom-free under this form of therapy were in the atrophic group.

2. The medication used seems to have a palliative action in many cases of rheumatoid (atrophic) arthritis, and in this way it may favorably influence the course of the disease.

3. The medication used also appears to be of definite value in the hypertrophic type of arthritis and seems to confirm Reynolds' suggestion[4] that this preparation has antiarthritic properties.

4. This medication can be safely administered if the patient is carefully controlled during treatment and the dosage properly administered.

5. Good to excellent results were obtained in 32.3 per cent of proved arthritics when this medication and adequate orthopedic measures were judiciously employed; 91.8 per cent had subjective or objective improvement in varying degrees; no improvement of any kind was found or reported in 8.2 per cent.

6. In twenty-two patients with severe, chronic, active rheumatoid arthritis, who had been selected for subsequent orthopedic surgery, 63.6 per cent (fourteen) were considered favorable results while 36.3 per cent (eight) were classed as unsuccessful.

7. Symptoms of intolerance to the medication were observed in 14.4 per cent (twenty-six) of the patients.

8. Patients who obtained benefit from the steroid complex used maintained their improvement without further medication even with return to full activity.

9. The serial x-rays taken did not reveal progressive calcification of blood vessels of the extremities or other untoward calcific sequelae.

10. X-rays did demonstrate a decrease in size of soft tissue fusiform shadows surrounding small joints, although no changes were revealed in the joint structures themselves. This was corroborated by clinical examination.

11. No correlation could be found betweeen symptoms of intolerance and nonprotein nitrogen or calcium blood levels.

12. No correlation could be found between any changes in nonprotein nitrogen, either elevation or decrease, before or during treatment, with clinical improvement or with evidence of intoxication.

13. No relationship was found between toxic manifestations and changes in kidney function with respect to retention of nitrogenous products.

14. Although a high incidence of uric acidemia is found in arthritic patients, on repeated tests no correlation could be found between clinical improvement and the blood uric acid level.

15. Since the symptoms of intolerance encountered in this study were not related to hyper-

(Continued on Page 89)

Neurogenic and Psychogenic Factors in Digestive Tract Disorders

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THE RELATIVE IMPORTANCE of the nervous system as an etiologic factor in both functional and structural diseases of the digestive tract has been the subject of much investigation and discussion. This paper is an attempt to correlate our knowledge of the subject by a survey of a rather extensive and often contradictory and speculative literature.

Evolution of the Nervous System

In order to bring out the relationship which exists between nerves and their tissues, let us briefly review the evolution of the nervous system from lower forms of life. Plant life exhibits many adjustments, called trophism, to changes in its surroundings; an example is that of a plant turning toward the light when placed near a window. In the animal world, the amœba, a one-celled organism, exhibits many of the biologic foundations of behavior, such as metabolism, contractility, irritability, and conductivity. As an amœba approaches a pin point, it will draw away. On the other hand, when it approaches a particle of food, it will surround and digest it. It will act positively and negatively to certain chemicals. It will contract up into an inactive ball when cold.

The next step up in animal life is the sponge, a multicellular animal which has no nerves. Many of its cells have flagella which cause water to flow in lateral holes and out the apex. If a needle is touched at the opening of one of these holes, that hole will contract but not the rest of the sponge. There is a little conduction from muscle cell to muscle cell, but the stimulation is limited to a small area. Next in scale of development are the sea anemone and jelly fish. Here there are specialized cells in the surface, with extensions running through the organism which transmit stimuli and cause contraction of the muscles of the whole organism—the effector-receptor or primitive nervous system. A slight impulse causes only a few muscles to respond while a strong stimulus may spread and cause the whole organism to contract. The stimulus spreads like ripples from a stone thrown into water. The wall of the intestine in man probably works in part in this same way.

The next higher stage in animal life is the development of special paths for these cell extensions or neurons, into bundles called nerves. Also, there is a breaking up of the conduction paths into relays, called intermediary neurons, consisting of sensory, connector, and motor neurons. The connections between these neurons are so made that impulses can pass in one direction only, and so arranged that impulses may pass to certain groups of muscles where they will bring about co-ordinated movements. The neuron is made up of a dendrite, a nucleus, and an axon. The axon may connect with a muscle, a gland, or the dendrite of another neuron. This connection, called a synapse, offers some resistance to stimuli. This resistance is lessened by such drugs as strychnine and caffeine, but increased by alcohol, anesthetics and sedatives. The function of the nervous system is to expedite conduction. It is made up of specialized cells for that purpose. The presence of a large number of intermediary neurons, forming nerves, spinal cord and brain, provides the basis for man's variable reaction, behavior, leaning, and reason.

Anatomy of the Autonomic Nervous System

The digestive tract receives a double nerve supply through the two divisions of the variously named autonomic, involuntary, vegetative or primative nervous system. The term autonomic designates that part of the whole nervous system which supplies the glands, heart, blood vessels, digestive tract, and all other smooth muscle. It is an aggregation of ganglia, nerves, and plexuses, widely distributed in the body, especially in the head, neck, and thoracic and abdominal cavities, which lies in part within the cerebrospinal system and in part is made up of ganglia which, in the process of body development, have wandered out to other parts.[19,24,26]

The two anatomically, physiologically, and pharmacologically differing divisions of the auto-

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nomic system are variously named the exciting craniosacral vagus, or the parasympathetic, and the inhibiting thoracolumbar, or the sympathetic, divisions. Each system consists of a series of connecting neurons, extending from their origin in the brain to their termination in the walls of the digestive tract, where they form the intrinsic intestinal plexuses.

The first neuron of each division has its origin in autonomic centers or nuclei of cells placed in the hypothalamic region of the diencephalon. The hypothalamus lies just dorsal to the sella turcia with its pituitary body, and just ventral to the dorsal thalamus. The structures of the hypothalamus surround the cavity of the third ventricle. These important centers, while as yet not exactly delimited, appear to react to various stimuli including electrical, drugs, products of metabolism, and endocrine secretions, including the pituitary whose secretion may possibly pass direct to the hypothalamus through a type of portal circulation described by Basir.[4] The pituitary receives a systemic blood supply from small branches of the circle of Willis. In the pituitary body are sinusoids from whence minute portal veins carry blood directly to the hypothalamus. The pathways of discharge from this hypothalamic area have not been finally demonstrated, but it appears probable that the fibers to the vagus proceed from the anterior part and those to the sympathetics from the posterior part of the area. Authorities feel that, on the basis of physiological and clinical evidence, this important hypothalamic region co-ordinates visceral activity, even in the absence of the cortex, and to a large extent regulates human emotions as well.[23] Lesser centers have been placed lower in the medula and cord.

In the craniosacral division, the first neuron from the hypothalamic centers goes through poorly defined pathways to the dorsal motor nucleus of the vagus nerve in the floor of the fourth ventricle, from whence the axon of a second neuron passes down through the vagus nerve, without interruption, into the terminal plexuses in the wall of the digestive tract. There, it synapses with ganglia having short postganglionic fibers. Portions of the vagus nerve pass through the celiac sympathetic ganglia. The fibers of the sacral part of this craniosacral division pass down through the cord, synapsing with ganglia located in the lateral column of gray matter in the sacral end of the cord. These ganglia send fibers out with the two to four sacral nerves running into the hypogastric sympathetic ganglia. There they synapse again wth ganglia which send postganglionic fibers to the intrinsic plexuses of the lower colon, bladder and genitalia.

In the thoracolumbar or sympathetic division, the fibers pass down through the cord, synapsing with ganglia in the lateral part of the cord. These ganglia send fibers out by way of the fifth to twelfth thoracic nerves, through the white rami into the sympathetic trunk. Most of these fibers do not synapse in the sympathetic trunk but pass, uninterrupted, in the splanchnic nerves to the celiac ganglia. There, they synapse with ganglia which send axons, running with the vagus fibers, to end-organs in the intrinsic plexus of the intestinal wall.

The intrinsic nerve apparatus lies in the plexus of Meissner in the submucosa, and in the plexus of Auerbach between the longitudinal and circular muscle fibers. It is felt most probable that these plexuses are made up entirely of terminal fibers from the vagus and sympathetic nerves, and contain no true nerve net or synapses between local elements. It has been suggested, however, that the intrinsic nerve plexus is arranged like a surveyor's chain, with ganglia sending fibers to the mucosa and muscle at frequent intervals. This matter has not been definitely settled, due to technical difficulties of study.

Before closing the anatomic consideration, one should mention the relationship of the higher centers of the cortex, where originate those ideas, perceptions, and emotions which so influence the digestive tract. Attempts have been made to define clear-cut autonomic representation in the brain but have not been very successful, and much more work remains to be done before any definite facts can be established. Suffice to say now that the afferent system, through the special senses, serves to bring the periphery into consciousness.

The afferent or sensory fibers from the viscera run, in general, through the same nerves as the efferent or motor fibers, to ganglia situated in the cerebrospinal system. These afferent fibers serve to initiate subconscious visceral reflexes. In general, such sensation is vague and poorly localized. Tactile sensation is lacking in the viscera, but temperature sensations may be felt to a degree in the stomach and colon. Pain cannot be produced by cutting or pinching. Pain sensations apparently arise only from marked muscle distention or

contraction, or, in case of the solid organs, from distention of the capsule.[10]

Physiological Considerations

The principal types of gastrointestinal motility are peristalsis and hunger contractions in the stomach; peristalsis and rhythmic segmentation contractions in the small intestine; and antiperistalsis, haustral contraction, and mass movements in the colon. When for any reason these activities become disorderly, there may arise manifestations varying from a mild to a severe degree. All of these normal motor activities have been observed after all extrinsic nerve connections have been cut. It has further been shown by Kuntz[12] and others that, when sufficient nicotine has been administered to paralyze all peripheral elements of the intrinsic nervous mechanism, rhythmic movements still persist, but these rhythmic movements lack the variations in tonus and amplitude which is present when the intrinsic nervous system has not been paralyzed. Only conditions which affect the muscle itself can vary them. It is therefore concluded from physiological experiments that the capacity to contract rhythmically is inherent in the muscle itself, but that motility of this type alone would be functionally inadequate, without the nervous mechanism, to bring about variations in tonus, amplitude, and force of contractions, to prevent spasm, and to initiate or co-ordinate peristaltic and other reflex movements in response to local stimuli. Alverez[3] advanced the gradient theory of peristalsis, based upon finding, in general, a gradually decreasing gradient of rhythmicity, tonus, and CO_2 production of the muscle from the beginning to the end of the canal. He believes that the inherent muscular element is more important in intestinal motor activity than are the nerves.

Inasmuch as simple behavior in man involves trophic behavior and reflex action, and in light of what we know regarding the anatomy and physiology, one must, when studying the effect of influence on the intestine, consider first the possible effect of the influence on the normal inherent rhythmic contraction of the muscle itself. Second, one can postulate a system of superimposed reflex arcs through one or more neurons. The shortest reflex would be directly through the local nerve plexus: the myenteric reflex or axon reflex. This would be the response, in the form of a local muscle contraction or a secretory effect, to a local irritation or inflammation. The next higher reflex would involve all the neuron whose axon ends in the intestinal wall: the so-called ganglionic reflex. In this case, there would be a more widespread co-ordinating effect, such as a peristaltic wave or a peristaltic wave synchronizing with a relaxing sphincter. The act of defecation in the infant, or in the unconscious state, is given as an example of this reflex.

The next higher reflex would involve a higher neuron with its ganglia located in its respective segment of the spinal cord: the spinal reflex. Examples of this would be the rectus spasm, or the tender areas — head zones — associated with intra-abdominal disease. Some authorities describe controlling spinal centers for defecation and believe that all reflexes reach this or a higher level.

Still higher reflexes would involve the autonomic centers in the hypothalamic region of the brain. Indeed, it is believed that most viceral reflexes are co-ordinated or correlated through this hypothalamic area. All reflexes arising through emotional reactions to external stimuli probably involve these centers, as they receive olfactory, auditory, vestibular, occular and striatal impulses, as well as impulses from the cerebral cortex. Vonderahe[23] has summarized the work which suggests that this hypothalamic area dominates metabolism, temperature, sleep and the autonomic system, thereby influencing the blood vessels, the endocrine and other glands, as well as the thoracic and abdominal viscera.

Mention should be made of the influence of vasomotor fibers on the blood supply of the organs, and of the important resulting effects. Stimulation of the vagus causes dilatation of the arteries of the alimentary tract. This is contrary to the coronary vasomotor supply where sympathetic stimulation causes dilatation.

Regarding the higher psychic centers in the cerebrum, while the exact nerve fiber tracts have not been traced, experimental and clinical evidence postulates their existence and their relation to association and conditioned reflexes. Neuron patterns for certain reflexes are inherited and unlearned; they require no thinking. Such reflexes involving the cerebral centers and the digestive tract may be entirely unlearned and automatic, such as, for instance, the first nursing of the newborn. These reflexes, however, become conditioned reflexes when they are modified by remembrances of past experience. Examples of conditioned reflexes would be the psychic secretion of saliva

or gastric juice when one sees, smells, or even recalls a dish of food which has previously given pleasure, or the anorexia and gastric atony which comes when one sees or recalls a food which has previously made one ill.

Local Disorders in the Reflex Arc

The nerve plexuses intrinsic in the intestinal wall have been shown to guide and regulate the response to the natural stimuli of the intestinal contents. When, however, the normal chemistry, bacteriology, or consistency of the intestinal contents is altered by drugs, cathartics, infections, abnormal food, or normal food at irregular intervals, then abnormal stimuli are produced and abnormal reflexes are set up. This is the basis of many of the disorders of motility and secretion.

The literature regarding actual pathological lesions in the nervous mechanism is fragmentary and often inconclusive. Kantor,[11] who has reviewed the literature, reports a study made by Leupold on twenty-three cases of tuberculosis enteritis. It was found that the plexuses of Auerbach were markedly involved by round-cell infiltration in those cases having diarrhea, while such findings were present in only three of the sixteen cases without diarrhea. Neurofibromatosis has been found to involve the intestinal nerves, not only in the intestinal wall but along the nerves in the mesentery, and also the sympathetic ganglia. Degenerative nerve conditions have also been found by Scheimpflug in acute conditions such as meningitis, pneumonia, arsenic poisoning and also many chronic conditions leading to inanition. Morse[16] and also Roaf[21] have found nerve changes in the enteric plexuses as well as the celiac and vertebral ganglia in autopsied cases of pellagra and pernicious anemia. McCarrison[15] and others have found similar conditions in beriberi. Bowing[21] assumed that Auerbach's plexus is completely paralyzed in terminal peritonitis.

Certain drugs display a selective action of the nerve endings of but one division of the involuntary nerve system. Thus ergotoxin paralyzes the sympathetics, while atropine likewise affects the vagus. Nicotine in small doses stimulates the ganglia of both systems, while larger doses paralyze. This perhaps explains the frequent occurrence of defecation after smoking, while chronic constipation is seen in excessive smokers.

Lesions of the vagus nerve occasionally occur when it is involved with mediastinal tumors or tuberculosis of the lung hilus. Both gastric atony and hypertonus have been reported with these vagus lesions. Such paradoxes are explained on the assumption the mild conditions stimulate while severe conditions destroy the nerve. Kantor[11] recites several reports from the German literature of vagus nerve or vagus nucleus changes in cases of gastric ulcer, together with several reports in which no such lesion has been found. There is no evidence that gastric ulcer is associated with diseases of the vagus nerve.

Diseases of the spinal cord and spinal nerve roots, such as cord tumor, myelitis, trauma, radiculitis and pressure from spinal arthritis, may be accompanied by segmental gastrointestinal as reflex function. Tabetic crises are explained as reflex phenomena due to the degeneration of cells in the posterior spinal ganglia.

Lesions at the base of the brain, such as occur in encephalitis, may involve the autonomic centers and produce their evidence in the peripheral autonomic nerves. Likewise, brain tumors may produce gastrointestinal symptoms from pressure or actual involvement of this hypothalamic region.

Cushing[7] has described acute perforating ulcers in the human stomach in cases of tumor or operation on the hypothalamic region. He also reported hypersecretion and hyperperistalsis following injection of pituitrin or pilocarpine into the ventricle. Acute gastric ulcers have been produced in rabbits by injecting pilocarpine into the cerebral ventricles. No chronic ulcers, however, have yet been produced by such stimulation of the hypothalamic autonomic centers.

When certain neuron patterns are repeatedly exercised by repeated stimuli, they tend to become habits. This is also the basis of the development of skills. When some local disease causes repeated reflex neuron patterns, such patterns also tend to persist and be exaggerated even after the local disease has disappeared. This is the explanation at times of the persistence of symptoms after enteritis or ulcer or gall-bladder disease has been cured.

The interrelation which exists between different regions supplied by the autonomic system is explained on the basis of reflexes which may act through sensory, motor, and vasomotor fibers. Time does not permit consideration of many of these reflex behavior patterns. Suffice it to mention only a few as examples. Appendicitis, biliary tract disease, or a distended colon may cause

pylorospasm or vomiting. A distended uterus often causes vomiting; on the other hand, a distended colon often causes increased menstrual pains, and colonic irritation from a cathartic may cause increased urterine contraction and increased flow. Eye strain may cause headache or gastrointestinal complaints; on the other hand, Pearcy and Allen[17] have demonstrated that distention of the stomach or intestine in man produces a reflex disturbance in vision by causing a ciliary hypotonia and retinal conjestion and edema, in addition to distraction of attention. Disturbance of the labryinth causes vomiting while, on the other hand, nausea or vomiting causes dizziness.

General Conditions Affecting the Autonomics

Based on the functional opposition and different pharmacologic responses of the two autonomic divisions, two clinical syndromes have been described, called, respectively, vagotonia and sympathicotonia. These conditions were assumed to be congenital and based upon the preponderance of activity of one or the other division. Further experience has shown that their conception and even the newer one of autonomic imbalance are not well defined and that such a sharp division does not exist. They may, however, throw some light on the neuropathic constitution, as abortive or mixed types are not uncommon. Provided one does not adhere too rigidly to certain criteria, one may observe some grouping of symptoms referable to the two divisions. The vagotonic type shows contracted pupils, slow pulse, slowing of the pulse on pressure over eyeballs, low blood pressure, skin cool but sweats easily, a tendency to dermatographia and urticaria, high sugar tolerance, hyperacidity, and a tendency to spastic gastrointestinal conditions, with relief by atropine. The sympathicotonic type shows dilated pupils, rapid pulse, increased pulse rate on eyeball pressure, warm skin, tendency to high blood pressure, low sugar tolerance, adrenalin glycosuria and deficient gastric juice, all aggravated by adrenalin and thyroid.

Akin to autonomic imbalance is autonomic hypersensitiveness, also assumed to be constitutional, in which the individual overreacts to all stimuli, normal as well as abnormal. It is as though the nerve synapses were amplifiers magnifying returns at the receiving ends. Such a condition is present in many neurotics.

The endocrine glands have a reciprocal relationship with the nervous system. It is not definitely known "which is the cart and which is the horse." It is definitely established that psychic impulses, such as fear, anxiety and rage, influence the activity of the endocrine glands. On the other hand, there is ample evidence of the effect of internal gland secretion on the involuntary nerve function. It is my opinion that the endocrine glands, as an etiologic factor in digestive disorders, have in the past been greatly overestimated. This opinion is based upon a study which I made some time ago on the incidence and character of gastrointestinal abnormality in many cases of frank endocrine diseases.[13] As a part of this study, I mentioned that out of ninety cases of marked hyperthyroidism only 36 per cent showed any digestive complaints. Among the hypothyroid cases about 60 per cent showed constipation, and the same percentage showed achlorhydria.

Diet deficiency is another condition now known to cause widespread changes in the autonomic nervous system. I have previously mentioned the findings in cases of pellagra and beriberi. Rose, Stucky and Cowgill[22] observed gastric atony in vitamin B deficient dogs. Gross[9] also found reduced gastrointestinal motor action in rats deprived of vitamin B. Plummer[18] found that a deficiency of vitamin B caused a reduced tone of the intestinal musculature, together with a reduced amplitude, rate, and length of contraction. Investigation and study clearly indicate, in regard to vitamin B deficiency in humans, that it is increasingly apparent that minor degrees of deficiency disease exist that find no place in current nomenclature. Mineral deficiency, especially calcium, has been shown to cause increased excitability and weakness of the neuromuscular system. Rhinehart[20] suggests using galvanic current sensitivity as a test for such latent tetany, and reports clinical success from administration of calcium in appropriate cases. Pernicious anemia is another condition adversely affecting the autonomic system.

Fatigue seems to be a very disturbing and common factor in cases of autonomic disturbance. Whether these people just fatigue easily, or whether they are easily influenced by some fatigue hormone, is not known. Toxins from both acute and chronic infections also are common causes of trouble, as well as excessive amounts of alcohol, nicotine, and caffeine in susceptible individuals.

Allergy, caused by a hypersensitiveness to certain foods, may also produce autonomic disturbances.

If hives or other allergic disturbances can be elicited in the history, one should be suspicious, but some cases of intestinal allergy occur in which there are no other symptoms and in which skin tests are also negative. In these, the use of elimination diets is the best way to detect the condition. In my experience, however, food allergy as a cause of digestive disturbance is much more rare than the present allergic literature would lead one to believe.

Psychogenic Disorders

That activities of the higher centers of the brain may greatly influence digestive processes is common knowledge. Let us now consider the mechanism involved.

There are certain fundamental physical factors common to all families and species, such as form, color, and types of muscles, glands, bones, or neurons, all of which are subject to individual variation. Inherited, unlearned reflex behavior is also a fundamental characteristic and is a past behavior record of the race, but as these reflex behavior patterns become modified in the individual by past experiences, they are said to be conditioned, and in this case become a past behavior record of the individual.

All matter becomes modified by past experiences, such as broken glass, creased paper, brushed hair, or muscles worked a certain way, leading to certain skills or habits.

Instincts are inherited activities which occur at higher neuron levels than do reflexes, and also involve the internal glands. Closely allied with instincts are the feelings or emotions, which have been defined as the organic expression of the instinct. Of these, we have the simple feelings of pleasant or unpleasant; the emotions, such as joy, fear and rage; and the moods which are less intense and of longer duration, such as anxiety, worry, depression, happiness and ugliness. Hippocrates classified man into five types based upon these temperaments. Instincts and their accompanying emotions may also be altered or prevented by past experiences. Education is merely a modification of unlearned activities based upon memory of past experiences.

Alexander[1] lucidly explains the different reactions seen in different individuals by an example involving the process of weeping or laughing, both of which are complicated psychomotor autonomic reflexes. He assumes a hundred individuals viewing a motion picture. In a certain touching scene, a certain group are unable to control their tears, a second group are much less moved, while a third group remain cold and unemotional. In another movie or another touching scene, many of this latter unemotional group will be unable to restrain their tears, while many of the former emotional groups may remain unmoved and without any increased lachrymal activity. The reason people react differently is based to a great extent upon their past history and experiences. These conditioned psychophysical mechanisms serve to explain likes and dislikes, custom, diet habits or perversions among individuals, families, and entire races.

Man's behavior, as previously stated, is more variable than other animals because of his larger number of intermediary neurons. In his relation to external things he may and often does adjust the environment to fit his behavior, such as wearing warm clothes or starting a fire when it is cold, or turning the radio on or off as he desires it. In many cases, however, he must adjust his behavior to fit the environment; instinct may make him want to do one thing but social form or the law may forbid it; he may not want to work but he must, out of self-respect or to support himself or family; or he may wish for money or other things but be unable to get them easily. It often becomes a dilemma as to what to do. Man is eternally in conflict between desires and the way of meeting them with the approval of society. Often his wishes may be frustrated or denied for other various reasons. It is in overcoming and making the best adjustments that produces the test of a healthy mental organism. Traits of personality have their basis in these past experiences, this education, these conflicts or compensated temperaments.

The reaction to faulty mental adjustment may be in several ways. By compensation, in which an individual gives an external appearance of self-satisfaction to cover up an inferiority feeling, or may appear smart to compensate for ignorance. By projection, in which one projects his own faults onto others. Examples of projection are the cursing of a hammer which hits one's finger, the breaking of a golf club after a poor shot, or the not infrequent attitude of the patient in which he tries to blame the doctor for his own circumstances. A criminal or one of loose morals is unduly suspicious of others. A paranoic sees no good

in himself, so suspects others. Another method is by rationalization, in which fictitious reasons are given for certain behavior in order to protect one's own reputation. The flight from reality of the person with dementia praecox is extreme rationalization. Another method is by an infantile reaction to the adult level of reality as an attempt to escape. Religion is a way out for some. One of the most common reactions to faulty adjustment seen by the medical man is that of conversion or hysteria, in which the faulty adjustment is converted or manifested by a bodily complaint.

While all theories regarding the etiology of the neuroses and psychoneuroses, such as the biologic, the pathologic or organic, the physiologic, or the behavioristic, assume some constitutional or hereditary factor as a background,[5] it is generally accepted that the inciting factors are repressed instincts, faulty adjustments to conflicts, and emotional instability as a result of past experiences and education, often traceable as far back as childhood. These neuroses develop in the face of situations, usually social, economic, or sexual, with which the individual cannot cope.[8,14-1,25]

Every psychic tendency seeks an adequate bodily expression. If this external expression is blocked, it is assumed that a sort of short circuit takes place through the hypothalamic autonomic centers and, hence, the emotion finds its evidence in other parts of the body with which these centers are connected. It is a substitute for the normal expression of a repressed emotion. It is a disguised external pathologic expression of an unconscious wish.

According to the psychoanalyst, every symptom is supposed to have a meaning. The part affected in a hysterical expression depends upon the specific nature of the repressed wish. A desire to escape and secure the protection of infancy, to be loved, cared for, and fed, is supposed to be expressed by gastric disorders because, in infancy, the first and greatest gratification was received through the stomach. Fear and anxiety seem to have a close connection with the circulatory system, while stubbornness, spite, and disappointment often find expression in the function of the colon. Gastric ulcer is explained as being secondary to continued hypersecretion, hyperperistalsis, and vascular spasm of emotional origin, operating through the hypothalamic area and the vagus.

The classification of the neurosis is in a state of flux and depends upon one's point of view. Symptomatically, they may be expressed by changes in the psychic processes and in functional disturbances in the somatic organs. While most cases have mixed symptoms, anxiety, fear, compulsions, or depressions, with variable degrees of hysterical conversion, symptoms in the bodily organs are the most common. The neurotic has enough ego left to keep his personality intact, he is maladjusted but not antisocial. The psychotic has utterly failed to adjust, and has broken with the group and become asocial.

It is felt that neurosis should be recognized by definite characteristics rather than by making such a diagnosis by exclusion. Most neurosis diagnoses can be made or suspected during the process of history taking and examination, and the patient may be handled accordingly.[2] It is, however, most important to keep in mind that a neurosis may be the direct or indirect result of some somatic disease, or a coexisting condition, as well as the cause of somatic symptoms. For instance, there is the case of a young man with encephalitis lethargica who, at the onset, showed only the typical purposeful movements of hysteria; a young women with emotional instability was thought to have an anxiety neurosis till later found to have a brain tumor; a man with pernicious anemia was for a time thought to be a psychoneurotic because of his symptoms. Another case was that of a woman who all through her life had been neurotic, then developed a diarrhea which for a time was thought to be of nervous origin but which later proved to be due to intestinal tuberculosis; for a period during the chronic diarrhea, she became quite psychotic and developed the skin eruption of pellagra, both of which conditions were cured by vitamin B administration. Comroe[6] reports a follow-up study on 100 cases of diagnosed neurosis, in which twenty-four were later shown to have also had definite serious organic disease.

It is now apparent that few patients are entirely psychic or entirely somatic, but that most patients have elements of each. Patients may be psychosomatic, somatopsychic, or both.

Comments and Conclusions

From a survey such as this, regarding the interrelationship between the nervous and digestive systems, the practicing physician receives the following impressions:

1. The digestive tract should be considered as a muscular tube containing certain glands, con-

strictions and dilations to facilitate its function. It is essentially an automatic organ endowed with a normal contractility, irritability, and rythmicity, and it is subject to the same adverse influences as other tissues. It is, however, abundantly supplied with nerves from the autonomic system, which serve to expedite conduction and bring about variations in motor and secretory activity as the need requires.

2. Conditions formerly diagnosed as nervous disorders are now, by improved methods of examination, increasingly being found to have actual organic disease of the digestive organs or their nervous communications.

3. Pathological changes in the nervous system connected with the digestive tract may be brought about by past or present infections, toxemias or deficiencies, thereby interfering with normal reflexes or inducing abnormal reflexes and causing disordered action. These pathologic changes may involve the intrinsic plexus, or any of the higher neurons in the sympathetic ganglia, spinal cord, vagus nerve, or hypothalamic region.

4. Stress should be laid upon the importance of recent developments in our knowledge regarding the hypothalamic region, which is now believed to contain centers which co-ordinate or correlate most visceral reflexes, as well as those involving the emotions and the special senses. It is probable that confusion in the action of these centers may take place when they are bombarded by adverse stimuli from any of their nerve connections, including the viscera, special senses, and cortex. It is also probable that the proper workings of these centers is influenced by general toxemias, infections, and the endocrines.

5. Disorders of the digestive tract of purely psychic origin are explained on the basis of a blocking or repression of the normal bodily expression of an instinct or emotion, with a sort of short circuit through the hypothalamic region and nerves to the digestive tract.

References

1. Alexander, J.: Functional disturbances of psychogenic nature. J.A.M.A., 100:469, 1933.
2. Alverez, W. C.: Nervous Indigestion. New York: Hoeber, 1933.
3. Alverez: W. C.: The Mechanics of the Digestive Tract. New York: Hoeber, 1928.
4. Basir, M.A.: The vascular supply of the pituitary body in the dog. Brit. J. Anat., 66:387, 1932.
5. Bauer, J.: Constitution and Disease. New York: Grune and Stratton, 1945.
6. Comroe, B. J.: Follow-up study of 100 patients diagnosed as neurosis. J. Nerv. & Ment. Dis., 83:679, 1936.
7. Cushing, H.: Peptic ulcers and the interbrain. Surg., Gynec., & Obst., 55:1, 1932.
8. Dunbar, J.: Psychosomatic Diagnosis. New York: Hoeber, 1945.
9. Gross, L.: Vitamin Deficiency. J. Path. & Bact., 27:27, 1924.
10. Hurst, A. F.: The Sensibility of the Alimentary Canal. London: Oxford Press, 1911.
11. Kantor, J. L.: Neurogenic and psychogenic disorders of the alimentary canal. J. Nerv. & Ment. Dis., 70:28, (July) 1929.
12. Kuntz, Albert: The Autonomic Nervous System. Philadelphia: Lea and Fehiger, 1934.
13. Lockwood, B. C.: The digestive tract and endocrine function. J.A.M.A., 85:1032, 1925.
14. Masserman, J.: Dynamic Psychiatry. Philadelphia: Saunders, 1946.

14-1. Levine, M.: Psychotherapy in Medical Practice. New York: MacMillan, 1943.

15. McCarrison, R.: Deficiency disease. London: Frowde, 1921.
16. Morse, Mary: The histopathology of the autonomic nervous system in certain somatic and organic nervous diseases. J. Nerv. & Ment. Dis., 45:1, 1917.
17. Pearcy, J. F., and Allen, J. D.: Studies on the visceral nervous system. Am. J. Physiol., 82:56, 1927.
18. Plummer, B. A.: Motility of intestinal tract in experimental heriheri and scurvy. Am. J. Physiol., 80:278, 1927.
19. Ransom, S. W.: Anatomy of the Nervous System. Philadelphia: Saunders, 1935.
20. Rhinehart, B. A.: Increased irritability of gastrointestinal tract. Radiology, 24:1, 1935.
21. Roaf, H. E.: Dietetic deficiencies. Proc. Roy. Soc. Med., 13:25, 1920.
22. Rose, W. B.; Stucky, C. J., and Cowgell, S. R.: Physiology of vitamins. Am. J. Physiol., 92:183, 1930.
23. Vonderahe, G. R.: Clinical application of the anatomy and physiology of the hypothalamus. Ohio State M. J., 32:315, 1936.
24. Wechsler, J. S.: A Textbook of Clinical Neurology. Philadelphia: Saunders, 1933.
25. Weiss and English: Psychosomatic Medicine. Philadelphia: Saunders, 1943.
26. White, J. C: The Autonomic Nervous System. New York: Macmillan, 1935.

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BILIARY TRACT SURGERY

(Continued from Page 71)

13. Routine drainage is of value, and early ambulation helpful.

14. Preoperative evaluation and treatment of all biliary tract surgical cases lessens postoperative morbidity and mortality.

References

1. Aronsohn, H. G., and Andrews, E.: Experimental cholecystitis. Surg., Gynec. & Obst., 66:748-768, 1938.
2. Feinhlatt, H. M.: The infrequency of primary infection in gall bladder disease. New England J. Med., 199:1073-1078, 1928.
3. Gatch, W.; Battershy, J. S., and Wakim, K. G.: Treatment of cholecystitis. J.A.M.A., 132:119-121, (Sept. 12) 1946.
4. Walters, W., and Snell, A. M.: Diseases of the Gall Bladder and Bile Ducts. P. 410. Philadelphia: W. B. Saunders Co., 1940.

DAILY HEALTH NEWS RADIO PROGRAM

The new radio program "Tell Me, Doctor" featuring health news of both a scientific and economic variety is appearing daily on several Michigan stations.

It is being sponsored locally by firms approved by the MSMS. Franklin Ferguson, famous NBC announcer, is the Voice.

Other State Medical Societies have become interested in using this same program in their states. Pressings of these 5-minute health news transcriptions are available to those societies at cost.

Clinical Results with Pyribenzamine

A New Histamine Antagonist in a Comparison with Benadryl

By Samuel J. Levin, M.D.
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It is generally believed that at least some of the symptoms occurring in allergic diseases, as a result of the antibody-antigen reaction occurring in the sensitized cells, are due to the liberation of histamine or a substance resembling histamine having a similar pharmacologic effect. Histamine antagonists, and similar drugs as they are developed, will play an increasingly greater part in the palliative treatment of the allergic diseases. For this reason, the introduction of new substances in this group are of great interest to those who deal with these conditions. We recently reported[4] our results using benadryl (B-dimethylaminoethyl benzhydryl ether hydrochloride)* in the treatment of allergic diseases. Subsequently we have had the opportunity of studying another antihistaminic compound which has been named pyribenzamine, by the manufacturer.† This substance has the chemical formula shown in Figure 1.

Mayer[5] and his associates have carried out extensive animal experiments indicating that pyribenzamine has a powerful antihistaminic action. In their work they showed that rats, guinea pigs, dogs and rabbits could be protected against many times the lethal dose of histamine with relatively small doses of the drug. It was also very effective in the prevention of anaphylactic shock in these animals. Such experiments were carried out by using histamine both by inhalation and injection with equally effective protection. These experiments on animals also indicated that this new drug has an extremely low toxicity.

Arbesman,[2] in addition, carried out experiments in humans which demonstrated the ability of pyribenzamine to prevent the formation of histamine and allergic wheals.

The ability of pyribenzamine and benadryl in the prevention of histamine shock and anaphylactic shock in guinea pigs has been compared.[3] It was found that pyribenzamine was much more effective in protecting these animals from lethal doses of histamine than was benadryl.

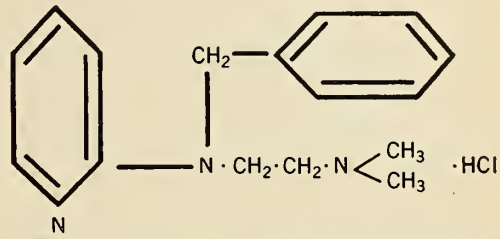

Fig. 1. Pyribenzamine hydrochloride (N′-pyridyl-N′-benzyl-N-dimethyl-ethylene diamine monohydrochloride).

However, the drugs were of equal value in the prevention of anaphylactic shock from horse serum. Clinically, Arbesman and his associates[1] reported that it produced relief in 70 per cent to 80 per cent of hay-fever cases, but found that it was somewhat less effective in the other allergic diseases.

Dosage.—The drug is supplied in 50 mg. tablets. The initial dose was 50 to 100 mg. (one to two tablets) every four to six hours. Although side-reactions occurred much less frequently with pyribenzamine than with benadryl, it would be advisable to order the first dose to be given in the evening so that if side-reactions occur no great harm would result.

Side-reactions.—Side-reactions occurred in our series in about 40 per cent of the patients. The chief side-reaction was drowsiness, but in only a few cases was it severe enough to warrant discontinuance of the drug. Gastrointestinal reactions occurred more frequently with pyribenzamine than with benadryl, and in some cases such distress, which was characterized by nausea or burning in the stomach, was severe enough to obviate the use of the drug. Other side effects noted were dizziness, faintness, headache, palpitation, nervousness and insomnia. A few patients complained of diarrhea and dryness of the mouth. Side-reactions could be lessened by reduction in dosage. On the whole side-reactions were somewhat less frequently seen and were less severe with pyribenzamine in this series than in our previously reported series of patients who were given benadryl.

*Parke Davis and Company, Detroit, Michigan.
†Ciba Pharmaceutical Products, Summit, New Jersey.
Dr. Levin is director of the Allergy Clinic at the Children's Hospital and is attending allergist at the Woman's Hospital, Detroit, Michigan.

In our much larger series of cases treated with benadryl, seven of 223 patients developed an aggravation of symptoms from the drug. No cases treated with pyribenzamine in this smaller series exhibited such ill effects.

TABLE I. SUMMARY OF PATIENTS TREATED WITH PYRIBENZAMINE

Diagnosis	Patients	Improved		Unimproved	
		Number	Per cent	Number	Per cent
Asthma, Seasonal	12	7	59	5	41
Asthma, Nonseasonal	6	3	50	3	50
Asthma with resp. infection	10	2	20	8	80
Allergic rhinitis, Nonseasonal	13	3	23	10	77
Pollen Hay Fever	18	10	56	8	44
Migraine	3	1	33	2	66
Urticaria, Acute	3	1	33	2	66
Total	65	27	41	38	59

TABLE II. COMPARISON OF PYRIBENZAMINE AND BENADRYL*

Diagnosis	Pyribenzamine		Benadryl	
	Patients	Per cent Improved	Patients	Per cent Improved
Asthma, Seasonal	12	59%	58	68%
Asthma, Nonseasonal	6	50	18	42
Asthma with resp. infection	10	20	11	18
Allergic rhinitis, Nonseasonal	13	23	14	28
Pollen Hay Fever	18	56	78	60
Migraine	3	33	18	60
Urticaria	3	33	11	65
Total	65	41%	223	60%

*Data on Benadryl from (4).

Results—Results are shown in Tables I and II. The effect of the medication was palliative only. Withdrawal of the drug was almost always followed by a recurrence of symptoms. A number of patients who were unable to tolerate benadryl had no side-reactions with pyribenzamine. However, the reverse observation was also made, i.e., benadryl was in some cases better tolerated than pyribenzamine.

It was also noted that some patients were relieved on pyribenzamine who had no relief from benadryl but again the reverse observation also was made, i.e., in some cases benadryl was more effective. In general, the impression obtained was that pyribenzamine was a somewhat less powerful drug than benadryl, from the standpoint of efficacy per milligram of medication. It should, however, prove to be a valuable addition to the list of drugs for the palliative treatment of allergic diseases.

Summary

1. Sixty-five patients were treated with pyribenzamine, a new antihistaminic drug, and forty-one per cent were improved.

2. The best results occurred in those patients having seasonal (pollen) symptoms.

3. The drug was much less effective in asthma, especially those cases associated with respiratory infection.

4. Side-reactions occurred in about 40 per cent of the patients. There was a greater tendency to gastrointestinal reactions with pyribenzamine than with benadryl. In general, side-reactions were less severe and less frequent with the former drug than with benadryl, which produced drowsiness more frequently than pyribenzamine.

5. Clinically, benadryl and pyribenzamine were not equally effective, the results being slightly better with benadryl. Some patients responded better to one drug than the other.

6. Pyribenzamine is undoubtedly of great value in the palliative treatment of allergic diseases.

7. It is obvious that the greater the number of such anti-allergic drugs available the greater the possibility of finding a particular one most suitable for, and best tolerated by, any given patient.

References

1. Arbesman, C. E.: Koepf, G. F., and Miller, G. E.: In press.
2. Arbesman, C. E.: Koepf, G. F., and Miller, G. E.: Some anti-anaphylactic and antihistaminic properties of N'-pyridil-N'-benzyl-N-dimethyl-ethylene diamine monohydrochloride (pyribenzamine). J. Allergy, 17:203, 1946.
3. Friedlaender, S.: Feinberg, S. M., and Feinberg, A. R.: Histamine antagonists. V. Comparison of benadryl and pyribenzamine in histamine and anaphylactic shock. Proc. Soc. Exper. Biol. & Med., 62:65, 1946.
4. Levin, S. J.: B-dimethylaminoethyl benzhydryl ether hydrochloride (benadryl). Its use in allergic diseases. J. Allergy, 17:145, 1946.
5. Mayer, R. L.: Antihistaminic substances with special reference to pyribenzamine. J. Allergy, 17:153, 1946.

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The Clinical Significance of Hoarseness and Wheezing Respiration

By Louis H. Clerf, M.D.
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SYMPTOMS ENJOY THE same relative importance in the diagnosis of disease as evidence does in a court room. The clinician must seek the evidencc and determine its significance to reach a diagnosis. Certain evidence can be secured only by interrogating the paticnt or his family, for symptoms may be subjective or of brief duration; other evidence is obtained by observation. Physicians may overlook important symptoms or fail to appreciate their significance, and arrive at erroneous conclusions.

In order to appreciate the significance of symptoms, onc should be familiar with the mechanism of their production. As a rule they are indicative of disturbances in function, and if one is familiar with the normal, it usually is easy to appreciate the significance of the abnormal. Many symptoms are subjective and are observed only by the patient. Hoarseness and wheezing respiration are objective and often are more readily observed by the patient's family or friends.

Hoarseness

Hoarseness, a disturbance of the voice, indicates that there is laryngeal dysfunction. It is a common objective symptom of laryngeal disease, is readily elicited, and is due to a disturbance of the phonatory function of the larynx. Normal laryngcal sounds are dependent upon approximation, tension and vibration of the vocal cords. Interference with one or more of these, results in disturbance of the voice. Obviously one must have an adequate air supply, and also normal resonators and articulators, to produce normal laryngeal sounds. Interference with these may produce changes in the voice, but this is not hoarseness, a symptom of laryngeal disease.

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Presented at the eighty-first annual session of the Michigan State Medical Society, Detroit, Michigan, September 25, 1946.

To determine the cause of hoarseness one must examine the larynx. A physician treating a patient suffering with hoarsencss either should be qualified to examine the larynx or should secure the assistance of one who is competent.

Causes.—The causes of hoarsencss are many and may bc local in the larynx or be of systemic origin. Hoarsencss may be the only demonstrable symptom of pulmonary tuberculosis, carcinoma of a bronchus or of the cervical esophagus, trachea or thyroid gland, mediastinal disease, allergy, blood dyscrasias, ancurysm of the arch of the aorta, cardiovascular or renal disorders or disease of the central nervous system. The local causes usually are acute or chronic inflammation, benign or malignant tumors, or nonspecific forms of nodulation, infiltration or ulceration.

Diagnosis.—To detect the presence of hoarseness it is necessary to examine the larynx. One cannot always make a diagnosis by mirror laryngoscopy. Often it is necessary to carry out certain systemic studies, including a roentgen examination of the chest, serological studies of the blood, studies of sputum, and biopsy from the larynx.

The causes of delay in diagnosis are many. The principal ones are failure of the physician to examine the larynx, misinterpretation of the findings secured by laryngeal examination, and failure of the patient to consult his physician. Little can be done to remedy the latter. While delay in diagnosis may not be serious in paralysis of the larynx due to aneurysm of the arch of the aorta, or in simple chronic laryngitis, the consequences in carcinoma may be very serious.

Carcinoma of the larynx involves the anterior half of a vocal cord in about 70 per cent of cases. As a result, such a lesion will interfere with normal laryngeal function, producing huskiness or hoarseness as an *early initial* symptom. Since carcinoma develops slowly and metatasis occurs late, its early recognition affords an opportunity to carry out appropriate treatment while the lesion still is localized and whcn from 80 to 90 per cent of these cases can be cured. That the facts do not bear out this is apparent whcn one reviews the cases of carcinoma that are seen in a large laryngeal clinic. More often patients present themselves with inoperable carcinoma or with growths that are so extensive that laryngectomy must be performed. A majority of these at one time were

early lesions that could have been cured by a relatively conservative form of surgical treatment.

Paralysis of the larynx rarely is caused by laryngeal disease itself. A majority of the cases are medical problems, originating either in the neck, thoracic cage, esophagus, trachea or central nervous system, or they may be toxic in origin. The importance of prompt recognition, so that appropriate medical treatment may be instituted, is apparent.

Tuberculosis and syphilis of the larynx commonly are considered as diagnostic possibilities when carcinoma is suspected. While tuberculosis of the larynx always is secondary to pulmonary tuberculosis, one not infrequently sees patients with hoarseness in whom no pulmonary lesion is suspected, and it is only when trying to determine the cause of the laryngeal lesion producing the hoarseness that a diagnosis of pulmonary tuberculosis is made.

A common diagnostic pitfall is the presence of a positive serological test of the blood for syphilis in one who has a laryngeal lesion. Syphilis of the larynx is rare in my experience. Before one concludes that a laryngeal lesion is syphilitic, it is important to rule out carcinoma and tuberculosis. Carcinoma can be ruled out only by biopsy taken from the lesion itself while tuberculosis of the larynx should be secondary to pulmonary tuberculosis. A roentgen study of the chest and examination of the sputum therefore are necessary. The diagnosis of syphilis of the larynx should be made by exclusion and not merely on the basis of a positive serological test.

Wheezing respiration.—This symptom is dependent on the ability of bronchial lumina to change during the respiratory cycle, and on the presence of partial bronchial obstruction. The wheezing sound is heard at the open mouth during and at the end of expiration and may also be heard over the chest.

Bronchologists who have observed the interior of the tracheobronchial tree during the respiratory cycle, and who are familiar with the appearances of the bronchi in the presence of obstruction, have observed the cause of wheezing respiration. They have noted that the diameter of bronchi increases and the air passages elongate during inspiration and the diameter decreases and bronchi shortened during expiration. In the presence of partial bronchial obstruction, as in the case of foreign body or new growth, the airway is greatly narrowed during expiration, and as air is forced through the narrowed lumen, a wheezing sound is imparted to it. This often is interpreted as a symptom of asthma or allergy, and patients are subjected to needless sensitization tests. Narrowing of a bronchus does occur in bronchial asthma as well as in many other conditions such as foreign body, endobronchial growths, either benign or malignant, stricture, granulation tissue and compression due to extrabronchial neoplasms, lymph nodes or aneurysm. When wheezing respiration is detected, a provisional diagnosis of *partial bronchial obstruction* would be more correct than a diagnosis of asthma.

When one observes patients with wheezing respiration roentgenologically during the respiratory cycle, or if radiographs are made at the end of inspiration and expiration, one commonly will find the presence of obstructive emphysema. This radiographic observation first was made in patients who had aspirated vegetal foreign bodies which produced partial bronchial obstruction with wheezing respiration. The significance of obstructive emphysema is identical with that of wheezing respiration, namely, trapping of air in a portion of lung, distal to a partial obstruction of a bronchus during expiration. It is during this phase that the involved lung appears emphysematous and as air escapes through the narrowed lumen of the bronchus the wheezing sound described as *wheezing respiration* may be heard. Forced expiration increases the intensity of the wheeze, as it is during this phase of respiration that the greatest amount of narrowing of a bronchus occurs. It should be evident that any patient with wheezing respiration should be studied roentgenologically to ascertain if there is present obstructive emphysema. This can be done only by observing the patient fluoroscopically or by having films made at the end of full inspiration and full expiration. The physical signs are not remarkable, for during inspiration the chest commonly is normal, and it is only during the expiratory cycle that the involved lobe or lung becomes emphysematous, and then a hyperresonant percussion note may be elicited. It is difficult to do this particularly in children. The auscultatory signs are probably the more important, for one can hear the wheezing sounds, and frequently there is a diminution in breath sounds over the involved lung.

The importance of wheezing respiration as a symptom should not be restricted to patients who have aspirated foreign bodies, but should be considered as of importance in all patients with partial bronchial obstruction. One of the most important conditions at this time, in which partial bronchial obstruction should be promptly recognized, is bronchial carcinoma. Bronchogenic carcinoma appears to be on the increase; at least more cases are being discovered, and it unquestionably is the most common form of carcinoma. Thoracic surgeons have demonstrated that early bronchogenic carcinoma is a curable disease. Unfortunately, however, a majority of patients with carcinoma of the bronchus still are not recognized as carcinoma until the lesion is far advanced, with complete bronchial obstruction and atelectasis or metastasis. It is important, therefore, that any patient with wheezing respiration should be recognized immediately as a probable case of partial bronchial obstruction, and appropriate investigations should be carried out. These would include physical examination, roentgen study of the chest, and bronchoscopy.

Phthisiologist long have recognized that tuberculous patients develop wheezing respiration, and they now are aware that this usually means a tuberculous tracheobronchitis. As a result, bronchoscopic investigation of the tuberculous is becoming a more or less routine procedure in many sanatoriums and always is indicated if there is wheezing respiration. The same diagnostic aids should be utilized in all patients who wheeze, to rule out foreign body, new growth and other forms of partial bronchial obstruction.

In retrospect one can profit by reconstructing the clinical progress of cases of advanced and often hopeless diseases. It would be found that many of these patients began with a husky voice or wheezing respiration many months previously. These symptoms often were attributed to something in the patient's environment or to certain of his habits, and little or no attention was paid to them until other symptoms developed. The patient then became concerned, his physician instituted appropriate studies, and a diagnosis was made; but too often, it was found that the case then was hopeless. It is important, therefore, to be aware of certain symptoms and realize that they are significant.

Any person who has a hoarse voice for more than several weeks should have a mirror laryngoscopy performed, and the case should be brought to a final conclusion. A diagnosis of chronic hoarseness is inadequate.

The patient with wheezing respiration should be considered as a potential case of partial bronchial obstruction which may be carcinoma but might be an evidence of allergy. In any event, the case should be properly studied and the cause of the wheeze determined.

The making of an inferential diagnosis has been described as a rapid method of arriving at a wrong conclusion. At this time, when many important diagnostic aids are readily available, it is imperative that every physician who takes care of patients with hoarseness either should be competent to examine the larynx or should have available the services of one who is competent. Any clinician who considers himself competent in the diagnosis and treatment of bronchopulmonary disease should avail himself of the services of a competent radiologist and should be familiar with certain signs and symptoms, also certain radiographic findings which indicate the presence of bronchial obstruction. Futhermore, he should be aware that direct visualization is necessary to arrive at final conclusions in the determination of the cause of obstruction to the airway.

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A CLINICAL STUDY OF 180 CASES OF ARTHRITIS

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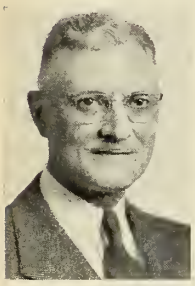
calcemia or renal damage, further clinical study of the physiologic effects of this compound may be indicated, particularly on liver function as suggested by Silver, Steck and Reed,[5] The study is continuing.

References

1. Correll, John T., and Wise, E. C.: The comparative toxicity of calciferol, A.T.10 and cod liver oil concentrate for chicks. J. Nutrit., 26:641, (Dec.) 1943.
2. Magnuson, Paul B.: Protein arthritis. J. Bone & Joint Surg., 8:839, (Oct.) 1926.
3. Reed, C. I.; Struck, H. C., and Steck, I. E.: Vitamin D—Chemistry, Physiology, Pharmacology, Pathology, Experimental and Clinical Investigations. Chicago: University of Chicago Press, 1939.
4. Reynolds, Chapman: Comparative therapeutic value and toxicity of various types of vitamin D. Journal-Lancet, 62:372, (Oct.) 1942.
5. Silver, A.; Steck, I. E., and Reed, C. I.: A Study of the Effects of Vitamin D on Capillary Permeability by the Use of The Dye T-1824. J. Lab. & Clin. Med., 29:48, (January) 1944.

Present Developments in Combined Anesthesia

By Ralph T. Knight, M.D.
Minneapolis, Minnesota



THE LAST SEVENTEEN YEARS have blessed anesthesiology with many new agents for the production of the anesthetic state and of many accompanying physiologic variations. Before this period, the phenomena of anesthesia had been so well studied that the pattern was described in great and fixed detail and divided into successive stages and planes of seeming invariability. New anesthetic drugs began to confuse this picture. While some of them followed the old pattern in a lax general way, the order and extent of depression of various elements of the nervous system might be greatly altered from the pattern we had come to know and revere. The new anesthetics presented a rather wide variety of qualities and talents.

Faced with this new and increasingly wide choice, anesthetists began to choose emphatically, declaring this or that agent to be the best, surpassing all others. This of course has proved not to be true. No one of them surpasses the rest except in certain respects. Some one of them, perhaps, modestly but actually surpasses the others in only one little way and disclaims other great attributes proclaimed for it by its proponents. Some one of them, perhaps, really surpasses no others in any respect at all, but is willing to join the others in helping to produce an over-all good anesthesia. It has come to the recognition of nearly all anesthetists that there is no good in championing any particular anesthetic. One's aim is to learn the best talents of as many of them as possible and to exploit them generously but delicately in the handling of each case, so that each drug is used in minimum for the effect which it best produces. The use of a large dose of the same drug to produce an additional effect which it produces inefficiently is to be avoided. Instead, another drug which produces this effect easily and efficiently should be added to the first one. Thus as many agents as necessary or advisable to spell efficiency should be used in sequence or coincidentally to bring about the summation desired. Ten years ago, Lundy used the term "balanced anesthesia" to express this concept, likening it to the "balanced diet" which had been popularized. Additional methods and techniques as well as additional agents have since then further extended the possibilities of balanced or combined anesthesia.

It is all well and good to joke about such methods, to accuse them of likeness to the old "shot-gun prescriptions," and to suggest that if one knew one or two agents well he would not have to resort to so many. The principle described still holds good and results in smoother, quicker recovery with less postanesthesia prostration.

A good example of effective combined anesthesia is the simultaneous use of sodium pentothal, curare and nitrous oxide.

Sodium pentothal is probably the best hypnotic we have ever had. The induction of sleep which it presents is an extremely pleasant sensation. The awakening from its effect is equally smooth and pleasant. One wonders whether in these times any patient should be subjected to other means of induction unless he dreads a needle more than a mask and even some measure of delirium. Of course there is still the rectal catheter but even this may be refused by some. I think it may be truthfully said that sodium pentothal produces efficiently no other effect than unconsciousness. A dose sufficient to block pain pathways and reflex arcs over-depresses the cerebrum and medulla. Muscle tonus is not reduced without still further central depression. Severe stimuli applied to the skin or other sensitive areas cause even violent reflex muscular movement unless a dose overwhelming to the brain is administered. A sleep too long and depressing then follows.

Curare, in the form of the presently available intocostrin, by Squibb, produces muscular relaxation by its action upon the neuromuscular junction. This is its efficient effect. In larger doses it may also have some analgesic action and in very large doses it produces unconsciousness. These effects should not be sought. The intercostal muscles and the abdominal muscles are relaxed at the same time, just as they are by large doses of the

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Presented at the eighty-first annual session of the Michigan State Medical Society, Detroit, Michigan, September 26, 1946.

potent general anesthetics, and the diaphragm is the last muscle to succumb. The use of intocostrin with sodium pentothal prevents reflex motion, assures quietness, and in increasing dose develops loss of muscle tone while accompanied by only a hypnotic dose of sodium pentothal.

Inasmuch as no effective analgesic is represented by these two, one seeks an addition of an analgesic drug which will produce little central depression. Procaine has been used for years intravenously to combat peripherally the torment of severe pruritus. More recently it has been used successfully to relieve the pain of burns, and very recently it has been used by Allen *et al* for the relief of the pain of childbirth. Procaine can be added to the intocostrin, thus considerably lessening the intensity of afferent impulses. This diminishes still further the dose of sodium pentothal necessary to maintain unconsciousness, and the dose of intocostrin necessary to prevent reflex motion.

I have found it impossible, when giving these agents separately, to judge which one of them is needed at any moment, and have decided it is best to administer them in fixed proportion from the beginning of the anesthesia. After trying various proportions I have adopted for the present a proportion of 10 units of intocostrin to each 25 mg. of sodium pentothal. I have used this for all types of cases, small plastic operations, eye operations, mastoids, laryngectomies, brain surgery, major intrathoracic surgery, cholecystectomies, colectomies and gastrectomies, and have not yet been much tempted to change the proportion. The total doses vary, of course, with the type of surgery, the length of operation and the individual. The dose of pentothal is surprisingly small, a gram seldom lasting less than two and one half or three hours and often lasting four or five hours. Awakening is almost always immediate and is quiet and pleasant.

In the beginning I used an amount of procaine equal to that of pentothal, and a much smaller amount of intocostrin; after a dozen cases I abandoned the procaine, feeling that it added to the length of sleep. The curare was then increased. The only difficulty I have had is the rather frequent occurrence of hiccups in the upper abdominal cases. This I believe is due to the lack of analgesic action, with resultant reflex contraction of the diaphragm, the only muscle left capable of responding, when upper abdominal attachments are tugged down. I have therefore again added the procaine, but only in proportion of 10 mg. to each 25 mg. of pentothal. More experience will be required, but it seems promising.

The sodium pentothal is injected from one syringe, and the intocostrin, or intocostrin and procaine, from another. Each is injected separately into a small-caliber, hard-wall rubber tubing, through separate B-D Gilson mixing adapters, or three-way stop-cocks. A constant drip of intravenous solution is kept moving through the tubing to keep the needle open and to separate the contents of the two syringes which tend to precipitate on mixing.

My associate, Dr. Joe W. Baird, has contrived to mix sodium pentothal and curare in the same syringe, and his report is in press.

Along with the intravenous use of these agents together, we have always added nitrous oxide and oxygen as soon as the patient is unconscious. The bag is first filled with 33⅓ per cent oxygen and 66⅔ per cent nitrous oxide. Thereafter a flow of 500 c.c. each per minute is maintained with the escape valve opened just sufficiently to keep the bag from distending. This we find by oxygen analysis maintains from 28 per cent to 35 per cent of oxygen. We believe that we should not submit a patient under anesthesia to less oxygen than this until we are able to use an oximeter on each patient and know that blood oxygen is kept up to normal on a smaller percentage of oxygen.

Nitrous oxide in this percentage is a pretty fair hypnotic and pretty fair analgesic, and reduces to some extent the amount of sodium pentothal and procaine required. With the nitrous oxide and oxygen constantly administered as described, small amounts of the intravenous agents are injected intermittently, in the proportion given above, as required to maintain the desired quietness and relaxation.

A mask or an intratracheal tube with inflated cuff are used as indicated and controlled respiration is used whenever it is thought desirable to increase the respiratory exchange, as at certain times in chest surgery or in abdominal surgery with deep relaxation.

MSMS

Editorial

THE EIGHTIETH CONGRESS

A New Year is started, and the future of the practice of medicine may be determined. The year 1946 saw many attempts to accomplish the regimentation of the profession. The progress of the advocates of Reform, Social Security, Compulsory Health Service was stayed when an aroused public voted that it had had enough control from above. This is just a lull in the program. All great social changes have had their ups and downs, and something good has ultimately resulted. The world is now in the throes of changes in every mode and fiber of its existence. There are many compelling forces at work, and a new theory of life may develop.

Many bills have been introduced into Congress and the various state Legislatures looking to the control of the phase of national life and welfare in which we as doctors are especially interested. With the new Congress many new bills are likely to appear. They will be sponsored by persons already known with whose methods of action we are familiar, and also by some entirely unknown men who may appear as sponsors of new measures.

It is expected that the Wagner-Murray-Dingell Bills will reappear, modified again, but fundamentally the same. It has been suggested that those bills can be changed to conform more with medical ideals, but they have passed through eight years and many revisions, and have so far shown no inclination to become anything we can endorse. If the medical profession wishes to have *anything* to say about its future freedom of action, or independence from bureaucratic controls, it must speak up. It must be willing to guide the framers of the legislation which will be enacted sooner or later to meet the demands of persons in the lower income walks of life who need medical security and who hope for some way to provide that security for themselves and their families.

This has all been said before and much better than we can say it, but it must be repeated. We are in the beginning of a new legislative biennial period; one facing many problems for the future of our country. Medical economics may prove to be a dominating factor in the solution of these problems.

NATIONAL HEALTH ACT OF 1947

The Taft-Ball-Smith Bill will be reintroduced in this Congress. Senator Taft has requested advice and help in rewriting his bill so that it will provide the services needed for national health protection, and not regiment or handicap the practice of medicine. A committee from Michigan has been working on this bill and has made some fundamental recommendations. Ideally, a National Health Bill should provide some very definite advantages. It should co-ordinate and group the various governmental activities having to do with health and unite them into one department of the government. They are now scattered, overlapping, and inefficient. They are all under the control of department heads who do not have the professional background, and who do not understand the ideals for which we are striving. To place them under one head with medical background would conduce to more efficiency, more uniform service and as a result would tend to a better national health.

The Public Health Service

Experiences of the past year have shown that the U. S. Public Health Service and its officials have failed to grasp the ideals of the leaders of the profession. They have advocated (possibly under duress) economic philosophy at direct variance with the profession. They have even tried to subvert and direct the political activities of the officers and employes of the department (See letter from the Surgeon General to the personnel of the department). This action was so flagrant that the House of Delegates of the AMA, in December voted an unanimous rebuke.

Hearings before the Senate Committee on Education and Labor have shown that the Wagner-Murray-Dingell Bills were drafted with the aid and direction of officers of the Service, including the Chief Statiscian. In matters of socioeconomic nature the department has lost the confidence of the profession. We are still willing to accept them in their rightful field of Public Health. We believe they are supreme in that regard.

Up to date, all National Health bills have been built upon the theory that the Surgeon General

(Continued on Page 94)

Michigan Postgraduate Clinical Conference

For a number of years the scientific papers delivered at our annual session each fall have had a national medical flavor, as the speakers have come from all parts of this country and Canada.

Recently a feeling has emanated from our executive offices that we hold a midyear meeting in late winter with an all-Michigan Program under the auspices of Wayne University College of Medicine, the University of Michigan Medical School and its Department of Postgraduate Medicine, Michigan Foundation for Medical and Health Education, the Wayne County Medical Society, and the Michigan State Medical Society, using the vast facilities of Detroit and nearby Ann Arbor.

Owing to the large membership in the southeastern portion of the State, added to the teaching and clinical material available, Detroit is the logical place for this type of meeting, especially as the next fall meeting will be held in Grand Rapids.

This session will not only provide us with the opportunity of hearing our excellent Michigan material, but will also prove a stimulus to the younger men in the Society to present papers and take part in the discussions.

Our first Michigan Postgraduate Clinical Conference will open on Wednesday morning, March 12, continuing through Thursday, March 13, and Friday, March 14. Luncheon meetings have been planned for Wednesday, Thursday and Friday. The full particulars and program will appear in a subsequent issue of The Journal.

Be sure to reserve these days for the latest innovation of *Your State Society*—an All-State Session of the Michigan State Medical Society.

President's

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William A. Hyland

President, Michigan State Medical Society

(Continued from Page 92)

of the Public Health Service would be the administrator, and that department of the government has been set aside as the dominant factor. This is also true of the first Taft Bill. We believe that the field of Public Health is simply one specialty of medicine, the same as surgery or pediatrics. We do not believe that department should be singled out to be the dominant force. We believe all the factors going to the preservation of the national health are co-equal, and have so suggested to the sponsors of the new bill.

Health Function of the Veterans Administration

We believe that another function of the government should be included in this group of departments that are being consolidated into a new division of the government, and that is the health function of the Veterans Administration. This is a fast growing department with a large staff of doctors and numerous hospitals, but still woefully inadequate to render the care which the disabled veteran is not only needing but which has been promised him by law.

Michigan has suggested and led the way in providing home-town care for the veteran, by his home doctor and hospital. This has been highly successful but is abounding in red tape and delays. This function should be divorced from the myriad other duties which are hampering the work. Also the professional care should not be controlled and directed by lay people. It should be separate and apart.

There are so many non-medical functions having to do with the care of the veteran and taking the time of the administration that delay is inevitable when medical care for the veteran is requested. Delays occur with too great frequency. We believe if this function of the department could be separated from financial, school, and other services, much of this delay could be eliminated.

We are aware of the wishes of veterans' organizations to place all veteran care in this Administration as a means to more prompt and more perfect care of the veterans, but we believe they will see the justice of our suggestion. At least, we shall try to provide what will be the best possible service for our veterans. They are our own brothers, sons, and selves, and we wish the best possible attention. They are not now getting what could be obtained.

This department of the government bids fair to become a major part of the nation's health service and it should be given the very best administration possible.

OTHER FEATURES OF THE TAFT BILL

The Taft Bill provides for the care of the medically indigent through service by voluntary health plans, the state paying the premium, or part of it. The patient will be benefited by being removed from the indigent group where services may have been given begrudgingly—not by the doctor so much as by those administering the social services. Under a voluntary medical service program, the doctor and the patient will be benefited in that the independence and personal choice will be assured.

This bill establishes a new principle of government that groups may have voluntary deductions made from their salaries for payment of voluntary health service premiums. Further, the establishment of these plans is encouraged by the government as a measure to make available to all self-supporting persons a means for securing prepayment medical and health services.

There is nothing in the Taft Bill looking toward the regimentation of the medical profession, their classification, or control. Provision is made for the subsidizing of medical persons in poor or thinly habitated regions where, under present conditions, a doctor could not make a sufficiently good living to attract him to the community.

The Taft Bill represents the thought of hundreds of medical leaders in all sections of the country, including official approval of at least two State Medical Societies, and the Council on Medical Service of the American Medical Association. Our individual support may do much to avoid legislation that is inimical to the people's health and welfare.

ON THE RUN. . . .

Coronary thrombosis appearing more than two weeks after injury is coincidental.

* * *

In bleeding from duodenal ulcer melena precedes hematemesis, while in that from esophageal varices, the opposite is true.

* * *

Activity of the mammary ducts in the newborn are due to maternal endocrine stimuli and regress soon after birth.

* * *

The peritoneal cavity is usually sterile for about twelve hours after perforation of an ulcer.

—Selected by W. S. Reveno, M.D.

Proceedings of the Detroit Physiological Society

Session of October 17, 1946

The following topics were discussed, and abstracts are herewith presented:

Dihydrostreptomycin: Studies on the Chemical and Biological Characterization of a Streptomycin Derivative.

Q. R. Bartz, J. Controulis, H. M. Crooks, Jr., and M. C. Rebstock—(Contribution from the Parke, Davis Research Laboratories, Presented before the Medicinal Division of the American Chemical Society, Chicago, September 1946).

Dihydrostreptomycin was prepared by hydrogenation of streptomycin trihydrochloride or the crystalline calcium chloride double salt in the presence of Adams' plantinic oxide catalyst. One molecular equivalent of hydrogen was absorbed.

Investigation of the chemical and biological properties of the hydrogenated material yielded insight into the problem of the structure of the streptomycin molecule and showed dihydrostreptomycin to be a potent antibiotic. In the latter connection, Dr. Erlich and Mr. Joslyn of our laboratories found that the hydrogenated material possessed activity in *vitro* which was qualitatively and quantitatively comparable to that of streptomycin. The compound was tested against the following organisms: Escherichia coli, Bacillus subtilis, Serratia marcescens, Bacillus mycoides, Salmonella schottmulleri, Shigella paradysdenteriae (Sonne), Klebsiella pneumoniae, Straphlococcus aureus, Streptococcus (hemolytic), Streptococcus (nonhemolytic), and Mycobacterium tuberculosis. We are indebted to Dr. Guy Youmans of Northwestern University for studies with the tubercule bacillus.

In contrast to streptomycin, the dihydro derivative showed marked stability in the presence of aqueous alkali. Conditions which produced maltol from streptomycin did not result in the formation of this compound when hydrogenated material was similarly treated.

Dihydrostreptomycin was cleaved by methanolic hydrogen chloride in the same manner as streptomycin to streptidine and methyl dihydrostreptobiosaminide. Acetylation of the latter substance yielded a crystalline panta-acetate.

Cysteine and carbonyl reagents which inactivated streptomycin systems did not influence the stability of dihydrostreptomycin nor did ultraviolet studies show any evidence for the formation of a carbonyl derivative in the presence of thiosemicarbazide.

In conclusion, it is suggested that the hydrogenation of streptomycin involves reduction of a carbonyl group to an alcohol group.

The Utilization of Niacin, Pantothenic Acid, and Biotin By Lactating Women

Margaret Coryell. Research Laboratory, Children's Fund of Michigan, Detroit.

Niacin, pantothenic acid and biotin were determined microbiologically in the food, milk, and urine of ten healthy nursing mothers during 5-day periods at various stages of lactation. In addition, N'-methylnicotinamide chloride was determined fluorometrically in the urine. Composites of the food eaten during each 5-day period and complete twenty-four-hour collections of milk and urine were analyzed.

During the first ten days postpartum the average daily milk volumes increased from 36 to 1223 ml. The average daily secretions of niacin and pantothenate in the milk rose from 0.04 to 2.94 mg., and from 0.01 to 3.45 mg., respectively. Only traces of biotin were present during the first four days, but the average increased to 4.6 micrograms by the ninth day, rising to 13.1 micrograms on the tenth day.

The average intakes of niacin, pantothenate, and biotin during seventeen five-day periods in which the women were secreting mature milk were 19.0 mg., 8.0 mg., and 80.8 micrograms, respectively. The average niacin secretion in milk and excretion in urine were 1.34 and 0.59 mg., respectively. N'-methylnicotinamide in the urine averaged 4.01 mg. The pantothenate values for milk and urine were 1.72 mg. and 4.47 mg., respectively, while those for biotin were 5.68 and 37.9 micrograms, respectively.

Effects of Water-Soluble Vitamins in Experimental Pancreatic Diabetes.

W. E. Ciszewski, J. C. Mathies, and O. H. Gaebler. Henry Ford Hospital.

The effect of moderate deficiency of water-soluble vitamins was studied in three depancreatized dogs receiving constant and adequate amounts of food, insulin, pancreatin, and haliver oil. In one animal marked glycosuria was produced five times by withdrawing yeast from the diet or by feeding the yeast-free diet supplemented with thiamine, riboflavin, and niacin. The glycosuria was accompanied by loss of weight and nitrogen, and also by an increase and prolongation of the alimentary hyperglycemia which followed the morning meal. On the other hand, there was no ketosis, even when 70 gm. of glucose was excreted per day. In a second animal only moderate glycosuria was produced in similar experiments. This could be abolished by increasing the dose of insulin or by completing the diet. Experiments on a purified diet containing adequate amounts of choline showed that the glycosuria which developed in the presence of thiamine, riboflavin, and niacin could be abolished by the further addition of pyridoxin and pantothenic acid. In a third animal no relationship between vitamin intake and glucose output could be demonstrated, even when succinyl sulfathiazole was added to the diet in an effort to limit synthesis of vitamins by intestinal bacteria. When the insulin dose was lowered about 4 units below the animal's requirement on a complete diet, the glycosuria which resulted tended to be diminished by withdrawing essential vitamins and increased slightly on adding them again. This anomaly may be due to the established fact that absorption rates are diminished during deficiency.

Session of November 21, 1946

Some Aspects of Experimental Bronchodilator Action of Drugs Structurally Related to Epinephrine.

O. H. Siegmund, Frederick Stearns and Company, Detroit.

Four compounds, including epinephrine and three N-substituted homologues of epinephrine, were discussed from a broncholytic standpoint, and in the light of the possibility that the data obtained in the investigation might suggest a change in the Cannon-Rosenblueth theory. The four compounds in the series were the primary amine of 1-(3′, 4′-dihydroxyphenyl)-2-aminoethanol; the N-methyl-(epinephrine); N-ethyl- and N-isopropylamine.

Guinea pigs, weighing 250 to 350 gm., were used as experimental animals. Asthma was produced in these animals by subjecting them to a histamine mist in a closed chamber. Reaction times, measuring the onset of asthmatic symptoms and total time necessary to produce asphyxial convulsions, were recorded and the animal permitted to recover. The same animals were then injected intraperitoneally with the compounds to be tested, and fifteen minutes after injection were again exposed to the histamine mist. The reaction times were again recorded and compared with the control times. Six minutes of exposure to the mist without evincing symptoms was considered to represent 100 per cent protection. All four compounds were compared directly at two dosage levels; 0.025 mg. per kg. and 0.1 mg. per kg. The primary amine was by far the weakest in activity, increasing the reaction time only a few hundredths of a minute over the control at the 0.025 mg. per kg. level, and approximately doubling the control time at the 0.1 mg. per kg. level. The other compounds: methyl, ethyl and isopropylamine, were quite close in action at the 0.025 mg. per kg. level, but showed a marked increase of reaction time directly proportional to the size of the N-alkyl group at the 0.1 mg. per kg. dose. The onset of asthmatic symptoms in controls was 0.78 minutes; while at 0.1 mg. per kg. of the primary amine it was 1.75 minutes; the methyl compound gave 3.38 minutes, the ethyl 3.78 minutes, and the isopropylamine increased the time to 4.91 minutes. Only the isopropyl compound was tested in a significant series at doses over 0.1 mg. per kg. At 0.15 mg. per kg., the reaction time was increased to 5.26 minutes, whereas, at 0.2 mg. per kg. all but an occasional animal resisted asthma for six minutes or longer. Preliminary work on the other three compounds indicated that none of them conferred an equal degree of protection at like doses.

Since experiment has indicated that sympathin-I effects can be produced by the introduction into the body of a chemical substance varying slightly from epinephrine, it would appear that this compound is a possible synthetic sympathin-I, with considerable potential therapeutic use.

PROCEEDINGS OF THE MSMS HOUSE OF DELEGATES—1946

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MICHIGAN STATE MEDICAL SOCIETY

Eighty-First Annual Session

PROCEEDINGS OF THE HOUSE OF DELEGATES

Book-Cadillac Hotel, Detroit, Michigan

(Continued from December issue.)

Monday Evening Session

September 23, 1946

The meeting convened at eight-thirty o'clock, P. L. Ledwidge, M.D., the Speaker, presiding.

THE SPEAKER: The House will please come to order.

Is the Chairman of the Credentials Committee ready to report?

J. J. O'MEARA, M.D.: Mr. Speaker, the Credentials Committee has the credentials of 94 delegates, which constitutes more than a quorum and of which 50 per cent are not from any one individual county.

THE SPEAKER: Thank you, Mr. Chairman. If there are no objections from the House, this report will be accepted as the roll call of this meeting.

Are there further resolutions to be brought before the House at this time?

VIII—8. SPECIAL MEMBERSHIPS

W. R. YOUNG, M.D. (Van Buren): I have the following resolutions that I was instructed by my Secretary to present.

WHEREAS, J. C. Maxwell, M.D., Paw Paw, Michigan, has been in practice for fifty-one years and has maintained his membership in good standing for thirty-nine years in the Van Buren County Medical Society, Michigan, and

WHEREAS, The Van Buren County Medical Society has conferred upon Dr. Maxwell emeritus membership, therefore be it

RESOLVED, That the House of Delegates of the Michigan State Medical Society confer upon Dr. Maxwell emeritus membership in the Michigan State Medical Society.

* * *

WHEREAS, J. R. Giffin, M.D., Bangor, Michigan, has been in practice for fifty-two years and has maintained his membership in good standing for thirty-four years in the Van Buren County Medical Society, Michigan, and

WHEREAS, The Van Buren County Medical Society has conferred upon Dr. Giffin emeritus membership, therefore, be it

RESOLVED, That the House of Delegates of the Michigan State Medical Society confer upon Dr. Giffin Emeritus Membership in the Michigan State Medical Society.

THE SPEAKER: Thank you, Doctor. These will be referred to the Reference Committee on Amendments to the Constitution and By-laws.

VIII—15. MICHIGAN HOSPITAL—MICHIGAN MEDICAL SERVICE

ALVIN THOMPSON, M.D. (Genesee): I have been instructed by my County Society to present the following resolution. We think that it is quite important to all members of the Society, whether they are delegates or not. The resolution is as follows:

WHEREAS, The Michigan Medical Service and Michigan Hospital Service, jointly, known to the public as the Michigan Blue Cross Plan, is the largest voluntary organization offering a prepayment medical and hospital insurance service in the United States and includes over one-fourth of all subscribers to such plans in the United States, and

WHEREAS, The Michigan Medical Service and Michigan Hospital Service, the Michigan Plan, because of its size and the duplication of its activities, has become a recognized leader of such plans by the social workers, politicians and the public, and

WHEREAS, Any failure or division in the Michigan Plan at this time could only encourage and perhaps promote the passage of Federal Social Legislation, such as the Wagner-Murray-Dingell Bill, to control the public health and practice of medicine in the United States to the detriment of the health of the people of this nation, and therefore becomes of paramount importance to every doctor of medicine in Michigan and

WHEREAS, Certain individual members of the Michigan State Medical Society have caused to be incorporated in this state the Michigan Health Association, a co-operative association with $50,000 capital donated by Michigan Medical Service, to provide limited liability insurance for its members to cover in part hospital costs and to compete with Michigan Hospital Service, and

WHEREAS, Certain individual members of the Michigan State Medical Society have caused to be incorporated a second corporation, the Michigan Service Corporation, a $1,000 stock company; the same holding a 15 year renewal contract to be the exclusive business agent for the co-operative Michigan Health Association, and whose incorporators have stated their intent to donate the stock of this $1,000 corporation to the Educational Fund of the Michigan State Medical Society, and

WHEREAS, Such activities would advertise to the nation a failure or split in the parent Michigan Plan, and hence openly encourage social legislation, and

WHEREAS, Such a plan would put the Michigan State Medical Society in the hospital insurance business, a highly debatable and undesirable situation, and

WHEREAS, the differences between Michigan Medical Service and Michigan Hospital Service leading to this state of affairs appear not to be unsurmountable, therefore, be it

RESOLVED, That those members of the Michigan State Medical Society who are Directors of the Michigan Medical Service and who constitute a majority of the Directors thereof, are hereby instructed and required, individually and collectively, to proceed to resolve all differences between the Michigan Medical Service and the Michigan Hospital Service, in the method stated in Joint Operations Agreement, Section 12, between Michigan Medical Service and Michigan Hospital Service, dated August 23, 1943, and now in effect as follows, to wit: "All disputed matters and questions arising in connection with the execution and operation of this agreement shall be resolved and determined from time to time in the following manner: Medical Service shall designate two persons to act on its behalf, and Hospital Service shall designate two persons to act on its behalf as members of a Joint Operations Committee. The Committee so constituted shall consist at all times of four members. Each of the parties hereto may designate substitutes for any of the members acting in its behalf to attend any particular meeting. Any action taken by the Committee shall be evidenced by vote of the members of substitutes except as otherwise herein specifically provided. Meetings of the Committee shall be at such times as may be fixed by it. Special meetings of the Committee shall be called upon request of any member of the Committee.

The Committee shall promptly consider all matters and questions submitted by it or arising in the execution and operation of this agreement. Such determinations and regulations shall be reduced to writing and a record thereof shall be maintained by the Committee.

If, upon any matter being submitted to the Committee, the members shall be equally divided and a tie vote result, the matter shall be determined in the following manner: An umpire shall be elected by a majority of the members of the Committee with authority to cast the deciding vote upon such matter. In the event that a majority of the members of the Committee are unable to agree upon an umpire, then an umpire shall be selected who is agreeable to the parties thereto in such manner as the parties hereto shall determine, and further be it

RESOLVED, That the final determinations of such Joint Operations Committee be accepted as final and binding by the Directors of Michigan Medical Service provided the Directors of Michigan Hospital Service will also accept the final decisions of the Joint Operations Committee as final and binding upon the Michigan Hospital Service.

THE SPEAKER: This will be referred to the Reference Committee on Resolutions.

VIII—8. SPECIAL MEMBERSHIPS

L. C. HARVIE, M.D. (Saginaw):

WHEREAS, the following members of the Saginaw County Medical Society, W. B Clark, M.D.; J. N. Kemp, M.D.; and F. A. Poole, M.D., have fulfilled the requirements for Life Membership in the Michigan State Medical Society, having attained the age of 70 and having been members of the State Society for over ten years, be it

RESOLVED, That they be accorded Life Membership by this House of Delegates.

THE SPEAKER: This will be referred to the Reference Committee on Amendments to the Constitution and By-laws. Are there further resolutions?

If not, we shall go on to the next order of business, which is the *Reports of the Reference Committees.* We shall call first on the Chairman of the Reference Committee on Officers' Reports. Dr. Loupee.

XII. Reports of Reference Committees

XII—1. ON OFFICERS' REPORTS

a. *Report of the Speaker.*—The Committee approves the report of our Speaker and heartily compliments him on its studied preparation and his dynamic presenta-

tion. The Committee moves the acceptance of this report.

b. *President's Report.*—Your Committee gratefully acknowledges the report of President Morrish. With usual clarity he expresses the importance of public health and good public relations to the end that we may "spread the truth" regarding the high aims and purposes of private voluntary medical service.

c. *Report of Delegates to AMA.*—The Committee approves their advance position on questions of the extension of medical care to Veterans and Industrial groups and offers the thanks of the House of Delegates to them for their untiring efforts to extend and defend the private practice of medicine.

d. *Resolution by Dr. Babcock re Dr. Luce.*—Your Committee approves the spirit of this resolution but more fully to express the appreciation of the membership of this House of Delegates for the boundless energy and self-sacrificing service of Dr. Luce has amended the last two paragraphs of the resolution to read as follows:

"Be it Resolved that the Michigan State Medical Society does hereby thank Dr. Luce for his many years of work as a Delegate, express its deep regret that he finds it necessary to relinquish his position as a representative of our Society in the AMA and assure him that we shall continue to look to him for his valuable counsel and advice.

Be it further Resolved, that a copy of these resolutions be sent to Dr. Luce in the form of an appropriate scroll."

e. *Resolution by Dr. Riecker re Dr. James D. Bruce.*—The resolution was commended and approved as presented.

S. L. Loupee, M.D.: I move the adoption of the Committee's report.

(The motion was seconded.)

The Speaker: It is moved and seconded that the Committee's report be adopted as read. Is there discussion?

W. B. Harm, M.D. (Wayne): I would like to ask that next year the delegates report both meetings of the AMA. The delegates' report that I heard was only on the San Francisco meeting, and last year there were two meetings. Hereafter, I understand, they are going to have two meetings a year and I think both meetings should be reported to this body.

(The motion was put to vote and carried.)

The Speaker: The next order of business is the report of the Reference Committee on Reports of The Council. Dr. Eugene Osius.

XII—2. ON REPORTS OF THE COUNCIL

Eugene Osius, M.D.: Following is the report of the Reference Committee on Reports of The Council.

The Committee on the Reports of The Council wishes at this time to commend the members of The Council for the earnestness of their efforts and their many hours of work which they have so ungrudgingly performed during the past year. A vast amount of work has been carried out as evidenced by the full and complete report already listed in the Handbook and as read before the House of Delegates in session on Sunday evening, September 22, 1946. It realizes that a good deal of the report has to do with a new and untried field—namely, the Public Relations Plan, and many hours of thought and labor have gone into this particular phase. This Committee wishes particularly to call to the attention of the House of Delegates the untiring efforts which the Public Relations Committee has made in presenting for your study a complete and comprehensive plan to place our cause before the public. It hereby approves in toto the report of The Council for your consideration.

Eugene Osius, M.D.: I move the adoption of this report.

(The motion was seconded by L. G. Christian, M.D., Ingham, and carried.)

The Speaker: We shall now hear the report of the Reference Committee on Reports of Standing Committees, Dr. E. A. Oakes.

XII—3. ON REPORTS OF STANDING COMMITTEES

E. A. Oakes, M.D. (Manistee): Mr. Speaker, we shall take these in the order as they are in the Handbook.

The report of the LEGISLATIVE COMMITTEE as printed in the Handbook on Page 48 is approved by this Committee and we move its adoption.

The Speaker: Is there a second to this motion?

(The motion was seconded by L. E. Sevey, M.D., Kent, and carried.)

E. A. Oakes, M.D.: The report of the MEDICAL LEGAL COMMITTEE as printed on Page 49 of the Handbook is approved, and we recommend its adoption.

(The motion was seconded by W. B. Harm, M.D., Wayne, and carried.)

E. A. Oakes, M.D.: The annual report of the PREVENTIVE MEDICINE COMMITTEE on Page 50 of the Handbook is approved, and we recommend its adoption.

(The motion was seconded by Arch Walls, M.D., Wayne, and carried.)

The annual report of the CANCER COMMITTEE as printed on Page 51 and Page 52 of the Handbook is approved, and we recommend its adoption and recommend that greater study be given by the Committee on the control and approval of the clinics contemplated by this Committee.

I move its adoption.

(The motion was seconded by R. A. Springer, M.D., of St. Joseph and carried.)

The annual report of the MATERNAL HEALTH COMMITTEE on page 53 of the Handbook is approved, and we recommend its adoption.

(The motion was seconded by W. B. Harm, M.D., Wayne, and carried.)

The annual report of the VENEREAL DISEASE CONTROL COMMITTEE on page 54 of the Handbook is approved and we recommend its adoption.

(The motion was seconded by Arch Walls, M.D., of Wayne, and carried.)

The annual report of the COMMITTEE ON TUBERCULOSIS CONTROL as printed on pages 55 and 56 of the Handbook is approved, and we recommend its adoption.

(The motion was seconded by Dr. Stucky of Eaton and carried.)

The annual report of the COMMITTEE ON INDUSTRIAL HEALTH as printed on pages 56 and 57 of the Handbook is approved by this Committee, and we recommend its adoption.

(The motion was seconded by L. E. Sevey, M.D., Kent, and carried.)

The annual report of the COMMITTEE ON MENTAL HYGIENE as printed on page 58 of the Handbook is approved, and we recommend its adoption.

(The motion was seconded by W. B. Harm, M.D., Wayne, and carried.)

The annual report of the CHILD WELFARE COMMITTEE on page 59 of the Handbook is approved, and we recommend its adoption.

(The motion was seconded by Arch Walls, M.D., Wayne, and carried.)

The annual report of the IODIZED SALT COMMITTEE as printed on pages 60 and 61 of the Handbook is approved, and we recommend to the Committee that a further study be made on the amount of noniodized salt that is being produced and used in the State of Michigan.

I move the adoption of this report.

(The motion was seconded by W. B. Harm, M.D., Wayne, and carried.)

The annual report of the COMMITTEE ON HEART AND DEGENERATIVE DISEASES as reported on page 62 of tne Handbook is approved, and we recommend its adoption.

(The motion was seconded by F. G. Buesser, M.D., Wayne, and carried.)

The annual report of the COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION is approved by this Committee, and we feel that they are to be commended on their excellent postgraduate program.

I move the adoption of the report.

(The motion was seconded by F. G. Buesser, M.D., Wayne, and carried.)

The annual report of the ETHICS COMMITTEE as printed on page 72 of the Handbook is approved, and we recommend its adoption.

(The motion was seconded by L. G. Christian, M.D., Ingham, and carried.)

The Committee recommends that the report of the PUBLIC RELATIONS COMMITTEE as printed in the Handbook and brochure be accepted. The Committee further recommends that the criticisms that have come to their attention be carefully considered by The Council before enacting the program; and that The Council be empowered by this House of Delegates to utilize such agencies as may be necessary to obtain the best results.

I move the adoption of this report.

(The motion was seconded by L. G. Christian, M.D., Ingham, and carried.)

COMMITTEE ON DISTRIBUTION OF MEDICAL CARE

Mr. Speaker, I move the adoption of the report of the Committee as a whole.

(The motion was seconded by M. A. Darling, M.D., Wayne, and carried.)

The Speaker: I shall now turn the chair over to the Vice Speaker.

(J. S. DeTar, M.D., the Vice Speaker, took the chair.)

XII—4. ON REPORTS OF SPECIAL COMMITTEES

THE VICE SPEAKER: The next item in the order of business is the Report of the REFERENCE COMMITTEE ON REPORTS OF SPECIAL COMMITTEES.

P. E. SUTTON, M.D.: The Reference Committee on Reports of Special Committees considered the reports of eleven committees. I believe I may shorten this report considerably if I summarize that the committee moved the acceptance of each of these reports. We found no controversial material in them. The only comment we have to make is in connection with the Special Committee on Radio. That report is contained on page 77 of the Handbook. We move the acceptance of this report, as reported on page 77, hut wish to call attention of the memhers of the House of Delegates to the need of considering the continuation of this radio program. This was requested in the report by the Special Radio Committee.

Mr. Speaker, I, therefore, move that each of these reports of special committees be accepted as included in the Handbook, and the one report that is typed, that of the Committee on the Control of Rheumatic Fever.

THE VICE SPEAKER: You have heard the motion, that the reports of the Special Committees all he accepted, including the report of the Special Committee on Rheumatic Fever Control. Is there a second?

(The motion was seconded by R. W. Teed, M.D., Washtenaw, and carried.)

XII—5. ON AMENDMENTS TO CONSTITUTION AND BY-LAWS

THE VICE SPEAKER: The next item on the agenda is the report of the Committee on Amendments to the Constitution and By-laws.

R. H. HOLMES, M.D.: The Reference Committee on Amendments to the Constitution and By-laws respectfully requests permission to report at a later time, because of the fact that some of the material is not yet available and because of the perplexities of the problem presented to the Committee.

THE VICE SPEAKER: Is there any objection to granting this request?

It is granted. This Committee is requested to report at ten o'clock tomorrow morning.

XII—6. ON RESOLUTIONS

The next item on the agenda is the Report of the Reference Committee on Resolutions.

XII—6 (a). STUDY OF HEALTH CARE (VII)

ROGER WALKER, M.D.: The first resolution before the Committee on Resolutions was Dr. Pino's in regard to suggestions for increasing the distrihution of certain aspects of medical practice.

WHEREAS, The science of medicine has so advanced and the possibilities of its application have become so increasingly extensive,

WHEREAS, This places not only increasing responsibilities and opportunities on the General Practitioner but also requires increase constantly in new specialties and in the responsihilities and opportunities of these specialists,

WHEREAS, Such advance makes increasingly possible better actual and potential health care of the people and is the essential factor in increased longevity.

WHEREAS, The application of the extensive scientific principles of medicine and surgery can be comprehensively, adequately, and safely carried out only by or under the direction of those basically and specifically trained through modern medical education,

WHEREAS, This medical education requires necessarily many years and great expense,

WHEREAS, If modernly applied, this makes medical care under any system whatever increasingly expensive if distrihution is not scientifically modified,

WHEREAS, With all the long and expensive basic training and developed skills, the doctor of medicine has but two hands with which to distribute medical care,

WHEREAS, This fact limits his opportunities not alone in distributing the skills that he has developed at so great a cost in time and effort, but limits also the opportunities of accelerated development of his skills,

WHEREAS, Experience has now accumulated, demonstrating that under the direction of the doctor of medicine through medical associates, the distribution of medical care can be immeasurably enhanced at less cost, because of less cost in the education of such associates,

WHEREAS, Some therapeutic procedures of limited value have been exploited by groups basically untrained but calling themselves "doctor" and confusing the public mind in prohlems of health care,

WHEREAS, We should be in position through research and personnel under the direction of the medical profession to search for, examine, and bring to the people every vestige of possible or proved additions to health care,

WHEREAS, Young people in our colleges and universities are looking for vocational opportunities, and such opportunities can be most attractively further organized and catalogued for their choice in association with the medical profession,

WHEREAS, The science of the distribution of health care has become a necessary corollary of the theory and practice of scientific medicine, therefore, be it

RESOLVED, That the Michigan State Medical Society in co-operation with the Universities of the state of Michigan, set up an overall Commission to be known as "The Commission for the Study and Development of the Science of the Distribution of Health Care," and be it further

RESOLVED, That the various schools and teaching facilities of Medical Associates now in existence and in the process of formation, can be so organized and catalogued as to furnish the medical profession such assistance as to make increasingly the science of the distribution of medical care along with medical science, more comprehensive, usable and effective. This can be one answer to better public relations. It can help to make it unnecessary for the people to seek counsel of irregular practitioners.

The Committee on Resolutions moved that the resolution be referred back to the Commission to continue their studies with power to form subcommittees to handle the various phases of problems as they arise.

ROGER WALKER, M.D.: I move that this report be accepted.

THE VICE SPEAKER: You have heard the motion that this report be accepted, to the effect that the problem be referred back to the Commission for further study and the appointment of subcommittees. Is there a second?

W. B. HARM, M.D. (Wayne): I second it.

THE VICE SPEAKER: Is there any discussion?

T. K. GRUBER, M.D. (Wayne): Mr. Speaker, did you want to refer it to the committee, or did you want the committee to continue its study?

ROGER WALKER, M.D.: Our intention was this:

To have this committee refer the problem back to this Commission for further study, with power to appoint subcommittees as they see fit.

THE VICE SPEAKER: You have heard the motion. Dr. Harm, of Wayne, will you second the motion?

W. B. HARM, M.D. (Wayne): Yes.

THE VICE SPEAKER: Is there further discussion?

If not, all in favor say "aye"; opposed, "no." It is passed.

XII—6 (b). MEDICAL VETERANS PRIORITY IN PURCHASE OF SURPLUS SUPPLIES

ROGER WALKER, M.D.: Reslution brought in, in regard to essential medical equipment in the Armed Forces Reserve.

Whereas, In setting up medical offices it has been difficult for veterans to purchase essential equipment from the usual private sources; and

Whereas, There is considerable medical surplus property which was used by medical installations of the Armed Forces during the war and which is now stored in warehouses; and

Whereas, Since there is a shortage of practicing physicians, it is necessary for the public health that the medical veterans be properly equipped to serve their patients; and

Whereas, Veterans have priority for surplus medical material; therefore, be it

RESOLVED, That the Michigan State Medical Society be asked to request the governmental agencies concerned to simplify the entire procedure for obtaining surplus property in order that all former officers of the Medical Corps may be given priority in purchase of available medical equipment.

ROGER WALKER, M.D.: I move the adoption of this resolution, Mr. Speaker.

(The motion was seconded by Arch Walls, M.D., Wayne, and carried.)

XII—6 (c). MEDICAL VETERANS AFFAIRS—CREATION OF MSMS COMMITTEE ON

Whereas, The aftermath of the war has left many problems affecting veterans, some of which are of vital concern to the medical profession and are likely to require action on a state level; and

Whereas, Veterans' affairs are certain to increase in importance with each succeeding year; and

Whereas, The best interests of the medical profession will be served only if veterans' problems are under constant study and the latest information is available on the numerous ramifications of such problems; and

Whereas, It would appear that the most efficient method for the Michigan State Medical Society to achieve these ends and also to maintain adequate liaison with the Veterans Administration and Veterans Organizations on matters of medical policy is by means of a special committee; therefore, be it

RESOLVED, That the House of Delegates of the Michigan State Medical Society favors the appointment of a State Veterans Affairs Committee; and be it further

RESOLVED, That the members of such a committee should be composed of veterans.

ROGER WALKER, M.D.: I move its adoption, Mr. Speaker.
(The motion was seconded by William Bromme, M.D., Wayne, and carried.)

XII—6 (d). AMA CONTRIBUTION TO HEALTH EDUCATION PROJECTS

Whereas, The Michigan State Medical Society has supported a program of Health Education during the past five years, and

Whereas, Such Health Education is not purely of local, but also of national interest and value, therefore, be it

RESOLVED, That the delegates of the Michigan State Medical Society to the American Medical Association be instructed to initiate a study of a policy by which the American Medical Association could contribute a portion of the cost of such a program of Health Education carried on by any State Medical Society.

ROGER WALKER, M.D.: I move the adoption of this resolution, Mr. Speaker.
(The motion was seconded by L. E. Sevey, M.D., Kent, and carried.)

XII—6 (e). MEDICAL OFFICERS PROCUREMENT BY RATIO

Whereas, During World War II the American Medical Profession unhesitatingly answered the call of the Armed Forces for medical personnel and abided by their decision as to the number of physicians needed; and

Whereas, More than one-third of the entire medical profession entered the armed services, leaving a dangerous scarcity of physicians to care for the civilian population; and

Whereas, In planning for any future national emergency the health requirements of the civilian population must be given greater consideration because of the greater likelihood of enemy action against our industrial centers; and

Whereas, The Medical personnel requirements for the Armed Forces in World War II was on the basis of 7.5 medical officers per 1,000 men or one for every 133 men; and

Whereas, It is the general belief of medical veterans that this ratio could be materially reduced if medical officers were used solely where their professional training and experience was justified and were replaced by Administrative Officers in all duties where medical knowledge was not essential, and if more efficient methods of employment of medical officers was devised; therefore, be it

RESOLVED, By the House of Delegates of the Michigan State Medical Society that, in their opinion, the Armed Forces should consider doctors of medicine as a national resource, highly limited in numbers, that must be carefully husbanded in time of war and therefore urges the Surgeons General of the Army and Navy to consider in their future planning the utilization of medical officers essentially for their professional service with the end in view that they will be able to revise their estimates of need for medical officers.

ROGER WALKER, M.D.: I move the adoption of this resolution.
(The motion was seconded by E. A. Oakes, M.D., Manistee, and carried.)

XII—6 (f). STATUS OF SURGEONS-GENERAL

Whereas, Approximately 10 per cent of the personnal of the Army are members of the Medical Department; and

Whereas, In modern warfare, the care of the sick and wounded and the many ramifications of evacuation and hospitalization are major factors in the success of land or amphibious operations; and

Whereas, Food, clothing and supply have important and far-reaching medical aspects; and

Whereas, In the past because the Surgeon General of the Army has been limited to offering technical advice only, the use of his broad experience has not been fully utilized in the formulation of major plans and training; therefore be it

RESOLVED, That the House of Delegates of the Michigan State Medical Society strongly urges that the Surgeon General of the Army and of all other divisions of National Defense be made a member of the General Staff with a status co-equal to that of other major subdivisions of the General Staff; and be it further

RESOLVED, That a copy of this resolution be forwarded to the President of the United States, to each member of Congress and to each Senator from Michigan, to the Chairman of the House of the Senate Military Committee, to the Secretary of War, and to the Surgeon General of the Army.

ROGER WALKER, M.D.: Mr. Speaker, I move the adoption of this resolution.
(The motion was seconded by M. A. Darling, M.D., Wayne, and carried.)

XII—6 (g). ESTABLISHMENT OF GENERAL PRACTICE SECTIONS IN APPROVED HOSPITALS

Whereas, The House of Delegates of the American Medical Association have established an individual section on the General Practice of Medicine; and

Whereas, The General Practitioner has been recognized as a separate branch in the medical profession; and

Whereas, This group has shown its interest in this Section by registering 939 members in the Section at the 1946 American Medical Association meeting in San Francisco; and

Whereas, Their scientific Section meetings were well attended; and

Whereas, The House of Delegates have already voiced their approval of such Sections in the separate state and county societies that are component parts of the American Medical Association; and

Whereas, Sections on General Practice have been started in some recognized hospitals that are approved by the American College of Surgeons and the Council on Medical Education, and Hospitals have been accepted by those bodies; and

Whereas, Many hospitals have not established General Practice Sections in their visiting active staffs and their governing heads are doubtful whether such action has the approval of the bodies which set up the rules and regulations for the approval of their hospitals for interns and residents; therefore be it

RESOLVED, That the Delegates of the Michigan State Medical Society in convention assembled voice their approval of the establishment of Sections of General Practice in approved hospitals and that the Delegates from Michigan to the American Medical Association House of Delegates be instructed to introduce a similar resolution at the next meeting, requesting approval of that body; and be it further

RESOLVED, That a copy of this resolution be sent to the Hospital Committee of the American College of Surgeons with a request that their body voice approval of such Sections and include such in their Manual of Hospital Regulations.

ROGER WALKER, M.D.: Mr. Speaker, I move the adoption of this resolution.
(The motion was seconded by Arch Walls, M.D., of Wayne.)

R. S. BREAKEY, M.D. (Ingham): That resolution said something about the delegates to the AMA being requested. Previous resolutions have stated that the delegates to the AMA shall be instructed. I submit an amendment to the resolution, changing any other wording which I do not recall, to "that the delegates to the AMA be so instructed."

THE VICE SPEAKER: Do you wish to submit that in the form of an amendment?

R. S. BREAKEY, M.D.: I have already moved an amendment.
(The amendment was seconded by W. B. Harm, M.D., of Wayne.)

THE VICE SPEAKER: Is there any discussion on the amendment?

R. S. BREAKEY, M.D.: Probably that part should be read again, Mr. Speaker.

THE VICE SPEAKER: Would you like to read that portion of it?

ROGER WALKER, M.D.: "Resolved, That the Delegates of the Michigan State Medical Society in convention assembled voice their approval of the establishment of Sections of General Practice in approved hospitals and that the Delegates from Michigan to the American Medical Association House of Delegates introduce a similar resolution at the next meeting—" Is that what you want?

R. S. BREAKEY, M.D.: Be instructed to introduce.

THE VICE SPEAKER: The amendment is that the words "be instructed to" be inserted before "introduce." Any discussion on the amendment?

L. G. CHRISTIAN, M.D. (Ingham): For the benefit of Dr. Breakey, the delegates to the American Medical Association do not need to be instructed. They need to be requested. We have always carried out the wishes of the body.

R. S. BREAKEY, M.D.: Mr. Speaker, it is not a question of being requested. Dr. Christian and myself and Dr. DeVries and Dr. Shaw have come here for years and have been instructed by our local County Society to carry out certain representative thoughts. I have no doubt that the delegates to the American Medical Association will carry this out, but when they are able to say to the total House of the AMA, "We are instructed," they carry their position more firmly, and they cannot deviate.

THE VICE SPEAKER: Is there further discussion?

L. G. CHRISTIAN, M.D.: Mr. Speaker, we accept the discussion.

THE VICE SPEAKER: Is there any further discussion?

If not, we will proceed to vote on the amendment. All in favor of the amendment will signify by saying "aye;" opposed, "no." The amendment is passed.

Is there any further discussion on the main motion for the adoption of the resolution? If not, all in favor say "aye;" opposed, "no." The motion is passed.

Whereas, The Maintenance of standards of health and the treatment of the sick is the obligation of the medical profession; and

XII—6 (h) HUMANE USE OF ANIMALS FOR SCIENTIFIC PURPOSES

Whereas, Medical progress is dependent upon research for fundamental knowledge relating to the eradication of disease; and

Whereas, The present high standards of medical care are largely dependent upon the humane use of animals for the purposes of furthering our knowledge of disease, for the standardization of drugs, for normal teaching procedure and for diagnosis; and

Whereas, There is an effort on the part of erroneously informed individuals to interfere with the orderly and necessary humane use of animals for experimental purposes; be it therefore

RESOLVED, That the Michigan State Medical Society formally protest any interference with the humane use of animals for experimental purposes.

ROGER WALKER, M.D.: Mr. Speaker, I move the adoption of this resolution.

(The motion was seconded by W. B. Harm, M.D., of Wayne, and carried.)

XII—6 (i). SECTION ON UROLOGY, MSMS

Whereas, There have been recognized and approved by the Michigan State Medical Society eight specialty sections with scheduled meetings at the time of the annual meeting of the entire Society; these sections embracing the following specialties: Ophthalmology and Otolaryngology, Dermatology and Syphilology, Radiology, Anesthesia and Pathology, Surgery, Pediatrics, Gynecology and Obstetrics, Internal Medicine, and General Practice, and

Whereas, Urology is a specialty separate and distinct from these mentioned, and

Whereas, There has not until the present been established a Section on Urology of the Michigan State Medical Society, and

Whereas, Such a section is active and beneficial to all in the American Medical Association and many other state Medical societies, and

Whereas, It has been brought to the attention of the urologists of the Michigan State Medical Society that the American Urological Association urges this proper representation of the urologic field in this State Society, and

Whereas, Such a section would be mutually advantageous to both the urologists and the general practitioners; therefore, be it

RESOLVED, That a Section on Urology be established in the Scientific Assembly of the Michigan State Medical Society.

ROGER WALKER, M.D.: Mr. Speaker, I move the adoption of the resolution.

(The motion was seconded by F. G. Buesser, M.D., of Wayne.)

THE VICE SPEAKER: Any discussion?

W. B. HARM, M.D. (Wayne): I think that in order to make this an accomplished fact it will have to be referred again to the Committee on By-laws to form that section of the By-laws. Therefore, I wish to amend the motion, that this resolution be sent to the Committee on By-laws to be incorporated in the By-laws.

THE VICE SPEAKER: The amendment is proposed that this resolution be sent to the Committee on By-laws and Constitution. Is there a support?

E. D. SPALDING, M.D. (Wayne): Point of order! Is it necessary to have a revision of the By-laws? The By-laws provide that if, as and when this House of Delegates wishes to have such a section added, it may do so, by so voting.

THE VICE SPEAKER: There was no support to the amendment. Therefore, the amendment was dropped.

Is there any discussion? If not, all in favor of the resolution say "aye;" opposed, "no." The resolution is passed.

XII—6 (j). CO-OPERATION WITH NURSING AGENCY TO SOLVE PROBLEM OF NURSE SHORTAGE

INASMUCH as there exists today a critical lack in graduate nurses in the state of Michigan and throughout the nation;

INASMUCH as the schools of nursing have only one-tenth to one-half the enrollment they should have to meet current needs; and

INASMUCH as this shortage of nursing care may lead to a reduction of existing hospitals beds, the supply of which now available does not meet the public demand; and

INASMUCH as the Michigan Council on Community Nursing and all local component councils which have representation from organized medicine, the State Hospital Association, organized nursing, and the public have been given the responsibility of studying this problem and instituting ways and means of overcoming this situation; and

INASMUCH as the Michigan State Nurses Association, in co-operation with the Michigan State Hospital Association, has already established minimum personnel practices including wages, hours of work, vacations and other matters directly concerned with personnel practices; and

INASMUCH as organized nursing has already developed training programs for subsidiary workers to assist in the care of patients to give the best possible distribution of trained nurses; and

INASMUCH as committees of organized nursing are studying all phases of nursing education to attract young women into this field; therefore, be it

RESOLVED, That the House of Delegates of the Michigan State Medical Society instruct the Nursing Committee of the Michigan State Medical Society to co-operate with the existing nursing agencies concerned with this problem, and be it further

RESOLVED, That the House of Delegates consider an appropriation to assist in the public relations aspect of this problem.

ROGER WALKER, M.D.: Mr. Speaker, I move the adoption of this resolution.

THE VICE SPEAKER: It has been moved that this resolution concerning nursing be adopted. Is there a second?

M. A. DARLING, M.D. (Wayne): I second it.

T. K. GRUBER, M.D. (Wayne): Will you read the last couple of sentences?

THE VICE SPEAKER: Dr. Walker, will you read the last two sentences?

ROGER WALKER, M. D.: "INASMUCH as organized nursing has already developed training programs for subsidiary workers to assist in the care of patients to give the best possible distribution of trained nurses; and

"INASMUCH as committees of organized nursing are studying all phases of nursing education to attract young women into this field, therefore, be it

"RESOLVED, That the House of Delegates of the Michigan State Medical Society instruct the Nursing Committee of the Michigan State Medical Society to co-operate with the existing nursing agencies concerned with this problem; and be it further

"RESOLVED, That the House of Delegates consider an appropriation to assist in the public relations aspect of this problem."

T. K. GRUBER, M.D.: May I ask how we are going to arrange for that assistance—I take it, financial assistance?

ROGER WALKER, M.D.: That is what we assume it to be.

T. K. GRUBER, M.D.: How are we going to implement it? Will The Council be asked to do that, or how will it be implemented?

ROGER WALKER, M.D.: I believe it will be up to The Council to do so.

T. K. GRUEBER, M.D.: It might be well to ask The Councill to do it. I think it is a very important thing. All the doctors in the hospitals want nursing service. At the institution at Eloise we are paying the highest wages of any hospital in the country for nurses. We are paying general duty nurses $14.75 a day, and we have twenty vacancies right now.

Every hospital in the state and all over the country is short of nurses, and still you want your patients taken care of. If you don't have nurses recruited, the young women are not going into

nursing service, and you are not going to have nursing service in your hospitals.

I think this suggestion is fine, but I believe it ought to be implemented further.

THE VICE SPEAKER: I am going to ask Dr. Walker to read that one sentence again, regarding the public relations end of it.

ROGER WALKER, M.D.: "Resolved, That the House of Delegates consider an appropriation to assist in the public relations aspect of this problem."

THE VICE SPEAKER: Is there further discussion regarding this phase?

R. H. HOLMES, M.D. (Muskegon): Mr. Speaker, do we have such committee as a Nursing Committee? I never heard of one.

THE VICE SPEAKER: Oh, yes!

R. H. HOLMES, M.D.: Not a Nursing Committee. We have a Liaison Committee. Certainly, if you are going to pass that it should have the right name. There is no Nursing Committee.

THE VICE SPEAKER: Do you have the name of the committee in your resolution?

R. H. HOLMES, M.D.: We have "the Nursing Committee." I assume there is such a committee.

ARCH WALLS, M.D. (Wayne): Why couldn't the word "Council" be substituted for the House of Delegates in this last sentence?

THE VICE SPEAKER: Do you care to propose that?

ARCH WALLS, M.D. (Wayne): I would so propose a suggestion. I don't know whether we need an amendment.

THE VICE SPEAKER: If you care to change it, you had better propose an amendment and we will vote on it.

ARCH WALLS, M.D.: I would propose that amendment.

THE VICE SPEAKER: It has been moved that we amend the motion to read "The Council" instead of the "House of Delegates" to further implement the carrying out of the purposes of the resolution. Is there a second?

C. I. OWEN, M.D. (Wayne): I second it.

THE VICE SPEAKER: Is there any discussion on the amendment?

H. H. RIECKER, M.D. (Washtenaw): I think the original motion is too weak. We should have a new committee interested in developing this program. It is a very important thing. It bas been neglected. My opinion would be that it should be referred back to a committee for more positive recommendations to the House of Delegates.

THE VICE SPEAKER: Is there any further discussion?

T. K. GRUBER, M.D. (Wayne): I second that motion.

THE VICE SPEAKER: That was not a motion. We are now discussing the amendment, to strike out the words "House of Delegates" and substitute "The Council."

Is there any other discussion?

J. H. LAW, M.D. (Wayne): Is it not true that we have representatives on the Michigan Council for Community Nursing of the State Medical Society?

THE VICE SPEAKER: Dr. Foster?

THE SECRETARY: No.

THE VICE SPEAKERS We do not.

J. H. LAW, M.D.: It was my understanding that there was such a representation. I was thinking that it might be possible, after conference with the nursing group as to what their public relations needs might be, there could be a definite amount, as far as the appropriation is concerned. If there is no such representation, I think there should be established a special committee of the Society to co-operate with organized nursing in this important problem.

THE VICE SPEAKER: Is there any further discussion on tbe amendment that the words "The Council" be substituted for "House of Delegates?"

T. K. GRUBER, M.D. (Wayne): Isn't it possible to make a motion to refer the subject at hand to the committee?

THE VICE SPEAKER: It will be possible after we get through discussing the amendment.

T. K. GRUBER, M.D.: I don't believe you have to discuss the amendment. I believe you can always re-refer it.

THE VICE SPEAKER: There is an amendment on the floor at the present time for vote. If we vote down the amendment, we can vote to re-refer the entire report. Is there any further discussion on the amendment that the words "Tbe Council" be substituted for the "House of Delegates?"

R. S. BREAKEY, M.D. (Ingham): Mr. Speaker, if this amendment is defeated, the possibility for Dr. Riecker to make a new amendment still exists.

THE VICE SPEAKER: That is right.

R. S. BREAKEY, M.D.: To refer back to the Committee of the House. If we vote to refer this to The Council, that having passed, Dr. Riecker's amendment to go back to the Committee of the House will be ratber obviated, since we voted to send it to The Council, won't it?

If we wisb to do what Dr. Riecker suggests, we had better defeat this amendment.

THE VICE SPEAKER: Is there further discussion? We are discussing the amendment to substitute the words "The Council" for "House of Delegates."

E. D. SPALDING, M.D. (Wayne): Mr. Speaker, a point of order!

It is not necessary either to vote for or defeat this amendment. You can refer the motion and the amendment to tbe committee of the House.

THE VICE SPEAKER: The Chair believes that that motion does not take precedence over the motion tbat is on the floor at the present time, but if the House cares to defeat the present amendment on the floor, then we can refer this to a committee. Is that correct?

Is that agreeable to the House? Do you care to make such a motion?

R. S. BREAKEY, M.D.: There is a motion on the floor of the House now.

THE VICE SPEAKER: The Chair is in doubt.

ARCH WALLS, M.D. (Wayne): To make it more simplified, I will withdraw my amendment and refer it back to the Committee.

THE VICE SPEAKER: You wish to withdraw your amendment? Who seconded it?

(Dr. Owen, who seconded the amendment, agreed to the withdrawal.)

THE VICE SPEAKER: The amendment has been withdrawn.

The motion before the House is that we accept the resolution as read.

ARCH WALLS, M.D.: As read and refer it back to—

(Cries of "No.")

THE VICE SPEAKER: Do you want to make a motion that we refer it back to the Committee?

H. H. RIECKER, M.D. (Washtenaw): All I can say is that I think we should reject the sentence in the resolution and then go ahead with another resolution to strengthen the one submitted. Let's vote against this present motion to accept the report and then start over again.

THE VICE SPEAKER: The motion before the House is that we accept the resolution. Is there any further discussion?

S. L. LOUPEE, M.D. (Cass): There is still some doubt in my mind as to the first statement in this resolution. I wish the Chairman would read the first statement.

THE VICE SPEAKER: Will you read the first part of tbe resolution? Do you want the very first part?

S. L. LOUPEE, M.D.: The very first part.

ROGER WALKER, M.D.: "RESOLVED, Tbat the House of Delegates of Michigan State Medical Society instruct the Nursing Committee—"

S. L. LOUPEE, M.D. (interposing): That is not it. I want the whereases.

ROGER WALKER, M.D.: "Inasmuch as there exists today a critical lack in graduate nurses in the State of Michigan and througbout the nation;

"Inasmuch as the schools of nursing have only one-tenth to one-half the enrollment they should have to meet current needs; and

"Inasmuch as this—"

S. L. LOUPEE, M.D. (Interposing): That is sufficient. All right.

THE VICE SPEAKER: Is there further discussion on the motion that we accept this resolution?

T. K. GRUBER, M.D. (Wayne): Mr. Speaker, I move that the motion be re-referred to the Committee.

THE VICE SPEAKER: What committee?

T. K. GRUBER, M.D.: To the Reference Committee, and that the report be strengthened when it is brought back to the House.

THE VICE SPEAKER: It has been moved that the resolution be referred back to the Reference Committee for further study, to be presented to the House at the next session, or the next meeting.

W. B. COOKSEY, M.D. (Wayne): I support the motion.

THE VICE SPEAKER: Is there discussion on this motion?

E. A. OAKES, M.D. (Manistee): Mr. Speaker, I have been Chairman of the Committee on Nurses' Training Schools for several years, and some of you have been on the committee with me. I hate to say "I told you so" but the chickens are coming home to roost. We tried, beginning four or five years ago, to get the nurses in the state of Michigan to do something about recruiting nurses and to do something about giving us more training schools. They were interested solely in raising the standards of nursing, not in increasing the number of nurses.

At that time I was an advisory member of the State Board of Registration for Nurses, and Dr. Keyport and I almost had ourselves thrown out of the nurses' Committee meeting bodily because we protested.

The nurses are very much to blame for the situation in whicb they now are in themselves. They took out a number of schools around the state. Some of them needed to be taken out; that is true. In Owosso, for example, and over in Benton Harbor and a few areas where schools were large enough to train nurses, they refused to promulgate any kind of program except programs in large hospitals. They intimated that the smaller hospitals were not teaching nurses, that they were being used to perform services so the hospitals would not have to pay for those services. There was some truth in what they were saying, but I think a great deal of this situation has come about through the refusal of the State Board of Nurses to see the handwriting on the wall. I believe something should be done.

We have not been asked for two years now to attend any of these meetings of the nurses. The co-operation is not there that used to be. I would like to see it back again.

I think we should again extend a helping hand, as this resolution designates. Maybe by this time the nurses will have seen the light and maybe we can do a little something.

THE VICE SPEAKER: Is there any further discussion on the motion to refer this back to the Committee?

T. K. GRUBER, M.D. (Wayne): Mr. Speaker, along the line of what Dr. Oakes was saying, the object that the nurses have had before them is to increase the amount of training and education that young women should have to be nurses. It has always been my contention tbat it doesn't take a college graduate and three years in a nurses' training school to carry a bedpan, to hand some person a medicine, to give him a bath, to give him a "hypo." There are plenty of housewives who take care of their own children and relatives at home, who do those things. They have not been to college, and they have not had three years of nursing.

If we are going to continue to raise the standards of education we are not going to get nurses. What you doctors need is some person to take care of your patients. You do not need educated ladies' maids.

It would seem to me it is time the doctors were taking a band in the education of nurses to take care of their patients. They need somebody to look after their patients when they are sick.

They don't need a college degree. I think what Dr. Oakes says is correct.

THE VICE SPEAKER: Is there further discussion?

W. B. COOKSEY, M.D. (Wayne): I would like to speak to that same principle, without prolonging the discussion unduly.

While I presented this resolution, I was not the original maker of it, but this one principle particularly, it seems to me, is most pertinent that we discuss openly a little bit.

I would like to say that at least two hospitals in this ciy—and I can only speak of experience of two—have definitely been very conservative. One of them at least has been greatly at fault in trying to have superiorly educated nurses and has found itself behind in getting enough. It has had an entirely different change of personnel at the top, with a much more liberal policy along these very lines. The leaders in these two hospitals are talking about training subsidiary workers, whatever you want to call them, practical nurses or nurses' aides. They are recognizing the need for just this sort of thing, and we doctors may well be called upon to help in some of the training of these so-called nurses' aides or practical nurses to the end that Dr. Gruber speaks.

It is appropriate, it seems to me, that we recognize that fact. I believe personally that Dr. Oakes will find they are slowly developing because of pressure perhaps and the failure of past principles, there is slowly developing a very different and up-to-date sentiment in this matter among nursing circles.

J. H. LAW, M.D. (Wayne): I think, for the information of the House, it might be of interest to know, in any investment the State Medical Society might make, that organized nursing has just completed the first worthwhile survey of the nursing facilities both from the training standpoint and what the situation is in nursing. That is done in conjunction with the Committee on Nursing Care of the Hospitals.

There has been a change in thinking. A good many hospital administrators have made work studies of the duties that we consider nursing duties. There is going to be a segregation in training, and there will be this subsidiary group which I think is stated in the resolution. I agree in part with what Dr. Oakes and Dr. Gruber have said. We still have the need of the well-trained nurses, because nursing in many of its aspects has become a highly technical situation. If we are going to have adequate leaders in nursing, we are going to have to have some college graduate. We still need to maintain standards of training, just as we are interested in maintaining high standards of medical practice. The effort to maintain subsidiary workers is already under way. I think the work that the nursing aides have contributed during the war has pointed the way.

I think that a stronger resolution should come out of the committee, and I think that we need to support organized nursing in these serious problems facing us today, because it is very serious.

E. A. OAKES, M.D. (Manistee): I do not like to take up too much of your time, but I would like to say this, that in Manistee and in Cadillac there have been two schools for trained attendants. We were hoping to solve some of our difficulties about permanent help in our hospital, but lo and behold, the first class we graduated just melted right away. Where to? To Grand Rapids and Detroit. They grabbed them so fast it wasn't funny. Today the minute we graduate eight girls, just eight out of our little hospital, they come down to Detroit and their job is waiting for them. They are asked for, three months before they ever graduate; they are signed up. Those are trained attendants. They have had one year's training.

Four years ago, when we approached the Nurses' Committee and asked them, please, if they wanted to go on with their high standards of nursing, to grade their nurses in two grades, let us have one group of girls that are trained either three or four years if they want highly specialized nurses, and let us have another group and give them a year and a half or two years, so that we will have an adequate supply—because all of them couldn't get a college education in order to do nursing work—they couldn't see it that way. Yet they want to close our little trained attendant school up there at Cadillac and at Manistee, and they cannot see that the hospitals are taking these girls so fast because the need is there, and they are doing satisfactory work.

R. H. PINO, M.D. (Wayne): Mr. Speaker, in view of the fact that two hospital superintendents have just spoken, it is a good time to get a little message back to them and their hospitals and their boards of trustees.

A few months ago the Department of Ophthalmology in Harper Hospital decided if we could get nurses who understood our particular problems it would help us a great deal. So we said, "We will try to get some nurses to come in and take training." We put an advertisement in the *Nursing Journal* and also in the daily paper. We had sixty applications in the very next number. What did we say? We said that after three months' training we would pay them $225 a month. They would get the usual training, or the usual pay that the nurse gets up to that time, $225. The hospital, after we trained them, wouldn't do it. They came within $10 of doing it, and we have just two of the ten that we accepted left.

Now, hospital superintendents, the nurses, however you get them, are not going to work for pretty nearly less than the ordinary orderlies. Let's remember that. We are failing in what we undertake, and it is generally recognized that we need to start in, not only getting more nurses with less high-up training, but give them more practical training in the particular branches that some of them want to specialize in.

They won't stay. We have two left of the eight, and they are going to leave because they are not getting $225 a month. They are getting less than $225. Let's have in mind $225 and more, if we want to keep them.

H. H. RIECKER, M.D. (Washtenaw): I want to appeal to the House of Delegates once more to defeat this motion and consider after it is defeated a committee augmented by the Nurses' Association, and possibly Dr. Elliott of the Board of Education, a combined committee to study this and report to the House a solution for this problem.

THE VICE SPEAKER: Is there further discussion? The motion is to refer the resolution back to the House Committee for further study.

R. H. HOLMES, M.D. (Muskegon): I would like to offer a substitute motion that the resolution be referred to the Committee on Nurses Training Schools with authority, upon completion of this study, to report to The Council, and to authorize The Council to spend such funds as necessary for the program.

THE VICE SPEAKER: Will you turn around and restate the amendment, please?

R. H. HOLMES, M.D.: I offer as a substitute amendment that this resolution be referred to the present Committee we have, the Committee on Nurses Training Schools, with authority to make study and proposals to The Council, with further authorization to The Council to spend such funds as necessary to help establish this program.

THE VICE SPEAKER: You have heard the amendment as proposed. Is there a second?

L. E. HOLLY, M.D. (Muskegon): I support it.

T. K. GRUBER, M.D. (Wayne): Mr. Speaker, I believe you have to dispose of the report of your Reference Committee. Then you can make a motion to do whatever you want to, but that report of the Reference Committee has to be disposed of.

THE VICE SPEAKER: The motion to refer this back to the Reference Committee could be amended. The amendment has been made to refer it to the Committee on Nursing instead of the Reference Committee. That amendment has been seconded. Is there any discussion on the amendment?

The Chair will call on the Speaker to give us a parliamentary ruling.

THE SPEAKER: I am not a parliamentarian, but I do not believe you can dispose of it that way. I do not believe you can take a report out of the Reference Committee and refer it to some other committee altogether, which is not a committee of the House. I think you may amend your instructions to the Committee as to how to proceed in it, or what studies you want made, but I do not believe you can do it that way.

THE VICE SPEAKER: The Chair will, therefore, declare the proposed second amendment as out of order, and we are now discussing the amendment to refer this back to the Reference Committee. The motion to refer this to the Reference Committee is before you. Is there further discussion?

E. D. SPALDING, M.D. (Wayne): This has come from the Committee back to the House. It is in the lap of the House now, and you can put it anywhere you like. You can put it back in the first committee, or you can put it somewhere else. You don't have to put it back in the committee that it came from.

THE VICE SPEAKER: May I read from Robert's Rules of Order, that a motion to refer may be amended by changing or instructing the committee.

R. H. HOLMES, M.D. (Muskegon): Mr. Speaker, this is more or less a point of order. I cannot understand why you necessarily refer it back to the committee. You can change the committee if we accept that. The amendment will be of no avail until the motion of the committee is accepted. I think that is understandable. Therefore, if we go ahead and accept this amendment, and then we accept the original motion in the Resolutions Committee, then the Reference Committee is through, and instead of referring it to the special committee, we are referring it to a committee of the Michigan State Medical Society.

THE VICE SPEAKER: The Chair has accepted the advice of the Speaker to the effect that referring this to another committee outside of the House is not in conformity with the Constitution.

THE SPEAKER: I think I helped in getting Dr. DeTar into this. I believe what Dr. Holmes said is true, but I believe if you wish to offer such a motion you should offer a substitute motion instead of an amendment.

R. H. HOLMES, M.D.: I did. I offered a substitute amendment.

THE SPEAKER: There is no such thing as a substitute amendment. There is a substitute motion, or an amendment, whichever you wish to offer. If you wish to offer a substitute motion to refer this to some other committee, I think you may do that.

T. K. GRUBER, M.D.: Instead of spending a lot of time arguing about the parliamentary rules let us re-refer it, and Dr. Holmes can go to the Committee and tell them what he thinks, and the Reference Committee can put it in the report. I don't see how you can refer something to a committee that is not a Reference Committee.

THE SPEAKER: I think you can, Dr. Gruber, if, instead of accepting the motion of the Reference Committee to adopt their report, you move a substitute motion to refer this somewhere else. I think you can dispose of it. I think the House has authority to do it if it wishes.

T. K. GRUBER, M.D.: Mr. Speaker, at the House of Delegates of the AMA, the Board of Trustees recommended that a certain resolution be referred to a committee as a Reference Committee, and it was ruled that that could not be done, that it could be referred to someone else but the report of the Reference Committee first had to be accepted or denied.

THE VICE SPEAKER: All right. That is right, but in offering a substitute motion, the opinion of the Chair is this, that you do dispose of the original motion, provided the substitute is accepted. I believe that is right.

Do you wish to dispose of it that way? Are you ready for the question?

(Calls for the question.)

VOICES: What is the question?

THE VICE SPEAKER: The question is to refer this back to the Reference Committee for further study and report All in favor say

"aye;" opposed. Will you please raise your hands? We want to be sure. Will the Secretary please count? All opposed. The motion is carried. There is no question about it.

Dr. Walker has two more resolutions.

XII—6 (k). MEDICAL VETERANS REMISSION OF MSMS DUES

ROGER WALKER, M.D.: Appreciation of Dues by Veterans.

Whereas, Returning medical veterans have been faced with innumerable problems and considerable expense in re-establishing their practices; and

Whereas, The Majority of medical veterans have had their incomes considerably curtailed for the past several years; and

Whereas, The medical veterans are anxious to maintain their affiliation with the State Medical Society, therefore be it

RESOLVED, That the Medical Veterans of World War II express their very sincere appreciation to the Michigan State Medical Society for its remission of dues granted to the medical veterans.

The Committee on Resolutions recommends that the House of Delegates of the Michigan State Medical Society accept with thanks their expression of appreciation.

Mr. Speaker, I move the adoption of this report.

(The motion was seconded by W. H. Mast, M.D., Northern Michigan, and carried.)

XII—6 (l). ASSESSMENT ($25.00) FOR PUBLIC RELATIONS AND EDUCATION

ROGER WALKER, M.D.: The last resolution.

WHEREAS, Much progress has been made by the Michigan medical profession in effecting wider distribution of quality medical care; and

WHEREAS, Continued public education is necessary to continue and extend programs which have made for the better health of all the people such as we have begun; and

WHEREAS, $10 was appropriated in 1944 and $10 in 1945, and $25 in 1946 for the purposes of public education and all has been allocated except a reserve fund for exigencies; and

WHEREAS, A necessarily comprehensive program has been scientifically prepared and developed to meet the greater problems anticipated in 1947; and

WHEREAS, In 1947 the need will be more acute because it is a legislative year; and

WHEREAS, The public education-public relations program has shown great progress and will continue to grow, and financial provision must be made in advance to meet the requirements of the contemplated program; therefore, be it

RESOLVED, That a per capita assessment of $25 be levied for the year 1947 for purposes of public education and public relations.

Mr. Speaker, I move the adoption of this resolution.

(P. L. Ledwidge, M.D., the Speaker, resumed the chair.)

(The motion was seconded by E. A. Oakes, M.D., Manistee.)

THE SPEAKER: Did you all get that last part?

Is there any discussion?

R. S. BREAKEY, M.D.: Mr. Speaker, may I offer an amendment to the motion, in order to avoid too long discussion?

I should like to amend the motion to the effect that this be referred back to the Reference Committee for rewording, and that the sponsor of this resolution and the Committee on Public Relations be present at the meeting of the Committee on Resolutions, so that a satisfactory resolution may be presented tomorrow.

S. L. LOUPEE, M.D. (Cass): I will second that.

THE SPEAKER: The motion is that the report of the Reference Committee on Resolutions on this particular resolution be referred back to them for rewording.

Is there further discussion?

(The motion was carried.)

It will be referred back, and will be reported on tomorrow morning at ten o'clock or thereabouts. Are there further resolutions?

ROGER WALKER, M.D.: Mr. Speaker, I move the acceptance of the report of the Committee as a whole, as amended.

THE SPEAKER: The motion is to accept the report of the Committee as a whole, with these two exceptions which have been referred back.

(The motion was seconded and carried.)

THE SPEAKER: Thank you, Dr. Walker.

Are there further resolutions to come before the House?

VIII—8. SPECIAL MEMBERSHIPS

ALFRED LABINE, M.D. (Houghton-Baraga-Keweenaw): Houghton-Baraga-Keweenaw County Medical Society offers the following resolution in the names of Philip D. Bourland, M.D., and James B. Quick, M.D.—that being over 70 years of age and having maintained membership in good standing for over ten years in the State Society, they be accepted for life membership in the Michigan State Medical Society.

THE SPEAKER: The resolution will be referred to the Reference Committee on Amendments to the Constitution and By-laws.

VIII—16. PROCEDURE FOR PRESENTATION OF SPECIAL MEMBERSHIPS TO HOUSE OF DELEGATES

Are there any further resolutions?

D. W. THORUP, M.D. (Berrien):

WHEREAS, The presentation of candidates for special memberships in the Michigan State Medical Society is ordinarily made by the various delegates and

WHEREAS, The customary procedure of presentation of these candidates is time consuming and repetitious, therefore, be it

RESOLVED, That a Committee of the House of Delegates be appointed to deal with all recommendations for special memberships and be it further

RESOLVED, That all such recommendations for special memberships be presented to the chairman of this committee prior to the first meeting of the Annual Session of the House of Delegates for presentation in toto by the Chairman of this Committee at the Annual Session of the House of Delegates, and be it further

RESOLVED, That due and satisfactory notice of this procedure be given all secretaries of all county medical societies by information in the Secretary's Letters and by printed notice in The Journal of the Michigan State Medical Society for four succeeding months prior to the Annual Session of the House of Delegates of the Michigan State Medical Society.

THE SPEAKER: Thank you. That resolution will be referred to the Reference Committee on Resolutions.

VIII—17. TO ESTABLISH CLOTURE RULE IN HOUSE OF DELEGATES

Are there further resolutions?

R. S. BREAKEY, M.D. (Ingham):

WHEREAS, This House must be concerned with many and various interests of the constituent physicians whereby represented, and

WHEREAS, Upon too frequent occasion, the business of the House has been unnecessarily retarded by undue dissertation relative to one matter only, and

WHEREAS, It is desirable that the proceedings of the House be expedited to permit the expression of thought of the many interested and that the human tendency to elaboration should be controlled by definite regulation, and

WHEREAS, Such precedent has been established in civil legislative bodies and many medical societies by the establishment of cloture for limitation of the privilege of the floor, therefore, be it

RESOLVED, That reports of committees, special or otherwise, and presentation or discussion of all other business be limited to ten minutes upon the occasion of each separate recognition by the Speaker, with the exception of the Speaker's address, the President's address, the Annual Report of The Council, and such essayists before this House as may appear by invitation, and the response of the President-Elect, and further be it

RESOLVED, That at the expiration of this ten-minute period the recipient of the floor may be granted an additional five minutes upon the "per voce" vote of the members of the House in attendance.

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions.

Are there further resolutions?

Is there any other business you wish to bring before the House?

If not, the Chair would like to make two or three announcements.

(Announcements.)

I guess that is all. Thank you. Meet at ten o'clock tomorrow morning.

(The meeting recessed at ten-ten o'clock.)

Tuesday Morning Session

September 24, 1946

The meeting convened at ten-thirty o'clock, P. L. Ledwidge, M.D., the Speaker, presiding.

THE SPEAKER: The House will please come to order. Is the Chairman of the Credentials Committee ready to report?

J. J. O'MEARA, M.D.: I have the credentials of 101 members who have been certified by the proper authorities, which is more than the required number for a quorum, 50 per cent of which is not from any one county.

THE SPEAKER: Thank you, Mr. Chairman. If there is no objection this will be accepted as the roll call of the meeting.

(Announcements.)

We have visiting us at this time the Executive Secretaries of two other states, coming for the express purpose of finding out how our annual meetings are run. That includes the House of Delegates, the Exhibits, and the Scientific Sessions. They are John C. Foster of South Dakota and Ray Smith of Indiana.

We shall proceed with our unfinished business. Are there any new resolutions, or is there any new business to be brought up?

VIII—18. PRIORITIES FOR DOCTORS OF MEDICINE IN THE PURCHASE OF AUTOMOBILES

R. C. PERKINS, M.D. (Bay): I have a resolution:

WHEREAS, The veterans of World War II are impeded in their efforts to re-establish themselves in the practice of medicine by lack of adequate automobile transportation and

WHEREAS, Doctors of medicine who carried the increased burden of medical care during the war years find their automobiles worn to the extent that they no longer give satisfactory and dependable service, and

WHEREAS, Efficient and dependable transportation is necessary to the wide distribution of quality medical care, and

WHEREAS, Efforts to obtain priorities on new automobiles by the county societies have not as yet been successful, therefore, be it

RESOLVED, That the attention of The Council of the Michigan State Medical Society be called to this situation and The Council be urged to take such action as it deems advisable on the state level to obtain priorities for Michigan Doctors of Medicine for the purchase of new automobiles.

THE SPEAKER: This will be referred to the Reference Committee on Resolutions.

Are there further resolutions?

If not, we shall go on with our Reference Committee reports.

Is there a supplementary report of the Reference Committee on Reports of The Council?

Is there a supplemnetary report of the Reference Committee on Officers' Reports?

Is there a supplementary report of the Reference Committee on Standing Committees?

On Reports of Special Committees?

XII—5. ON AMENDMENTS TO CONSTITUTION AND BY-LAWS

The report of the Reference Committee on Amendments to the Constitution and By-laws. We have had no report on that. We sball ask Dr. Holmes to report on that.

R. H. HOLMES, M.D. (Muskegon): The following names have been proposed for Emeritus Membership in the Michigan State Medical Society:

J. R. GIFFIN, M.D. ..... Bangor
J. C. MAXWELL, M.D. ..... Paw Paw
ALEXANDER CRUIKSHANK, M.D. ..... Detroit
KARL DUBPERNELL, M.D. ..... Detroit
HUGH HARRISON, M.D. ..... Detroit
ARTHUR NORTHROP, M.D. ..... Detroit
ED. J. PANZNER, M.D. ..... Detroit
BURT SHURLY, M.D. ..... Detroit
ALEXANDER THOMSON, M.D. ..... Detroit
OSCAR W. McKENNA, M.D. ..... Flint
JAMES A. BAIRD, M.D. ..... Flint
LEE A. LEWIS, M.D. ..... Manistee
CLAYTON WILLISON, M.D. ..... Sault Ste Marie
GEORGE H. BAERT, M.D. ..... Grand Rapids
ALEXANDER M. CAMPBELL, M.D. ..... Grand Rapids
ROBERT J. HUTCHINSON, M.D. ..... Grand Rapids
REUBEN MAURITS, M.D. ..... Grand Rapids
MORTIMER E. ROBERTS, M.D. ..... Grand Rapids
C. P. DOYLE, M.D. ..... Lansing
GERTRUDE O'SULLIVAN, M.D. ..... Mason
THOMAS SANFORD, M.D. ..... Lansing

The Reference Committee recommends that they be made Emeritus Members.

I move that the recommendation be adopted.

(The motion was seconded by R. C. Perkins, M.D., of Bay, and carried.)

Resolutions that the following members be made Retired members of the Michigan State Medical Society have been considered by the Reference Committee:

JOHN D. BOEHM, M.D. ..... West Branch
HARLAN MacMULLEN, M.D. ..... Manistee
WILLIAM E. SHACKLETON, M.D. ..... Kalamazoo
LESLIE H. S. DeWITT, M.D. ..... Kalamazoo
GEORGE H. CALDWELL, M.D. ..... Kalamazoo

The Reference Committee recommends approval of these resolutions.

I move the adoption of the recommendation.

(The motion was seconded by L. W. Gerstner, M.D., Kalamazoo, and carried.)

The name of E. HOBART REED, M.D., was referred by resolution to our Committee to be elected as Associate Member of the Michigan State Medical Society, and the Reference Committee moves approval.

(The motion was seconded by E. D. Spalding, M.D., of Wayne, and carried.)

The following names have been recommended by resolution to life membership in the Michigan State Medical Society:

PHILLIP D. BOURLAND, M.D. ..... Calumet
JAMES B. QUICK, M.D. ..... Laurium
W. B. CLARK, M.D. ..... Saginaw
J. N. KEMP, M.D. ..... Saginaw
F. A. POOLE, M.D. ..... Saginaw
HENRY C. MILLER, M.D. ..... Hillsdale
HENRY F. HUGHES, M.D. ..... Cambria
E. A. MARTINDALE, M.D. ..... Hillsdale
ROBERT HARKNESS, M.D. ..... Hastings
E. P. BILLINGS, M.D. ..... Kent
CHARLES W. BRAYMAN, M.D. ..... Kent
JACOB D. BROOK, M.D. ..... Grandville
LOUIS CHAMBERLAIN, M.D. ..... Kent
WM. J. DuBOIS, M.D. ..... Kent
JOHN KREMER, M.D. ..... Kent
PETER J. KRIEKARD, M.D. ..... Kent
GEORGE LAMB, M.D. ..... Kent
WILLIAM D. LYMAN, M.D. ..... Kent
ALBERT NOORDEWIER, M.D. ..... Kent
CLYDE C. SLEMMONS, M.D. ..... Kent
WM. N. KENZIE, M.D. ..... Kalamazoo
ROSCOE F. SNYDER, M.D. ..... Kalamazoo
BURT D. WALKER, M.D. ..... Kalamazoo
RAY T. FULLER, M.D. ..... Kalamazoo
HERMAN A. RIGTERINK, M.D. ..... Kalamazoo
FRANK DUNN, M.D. ..... Lansing
FRED SEGER, M.D. ..... Lansing
JAMES HOUSTON, M.D. ..... Swartz Creek
JAMES E. CURLETT, M.D. ..... Roseville

The Reference Committee on Amendments to the Constitution and By-laws recommends to the House of Delegates that action on thse resolutions for Life Membership be tabled.

Mr. Speaker, I move the approval of the report of the Reference Committee on Life Membership.

R. S. BREAKEY, M.D. (Ingham): I second the motion.

THE SPEAKER: The motion is then that this list, whose names you have heard last, whose names have been presented for Life Membership, that action be tabled. Is there discussion?

W. B. HARM, M.D. (Wayne): Will the Chairman give us the reason for tabling?

THE SPEAKER: Will the Chairman of the Reference Committee give the reasons for tabling or recommending tabling these names?

R. H. HOLMES, M.D.: There are several reasons, and the situation became considerably complicated. Probably the main reason for tabling at this time is financial.

We have only 59 names submitted here. There are, however, available on the spot survey made approximately 400 eligible for life membership in the state, which means about 10 per cent of our membership. That 10 per cent would pay no dues, which would mean a lessening of our income by approximately $15,000 a year.

Particularly during this year, you are carrying some 1300 military members free of dues. We have, I think everybody realizes, particularly during this year, a great deal more expense than we have had before, and our need for money is quite vital. Therefore, it was thought that this should be postponed at least for this year, and then further action of the delegates could be taken as to what disposition should be made of this category of special memberships.

L. W. DAY, M.D. (Hillsdale): Among the list that has been rejected here are three applicants that I gave to the Committee. It seems to me to go back to my county and tell these three men that life membership is going to be withheld because we need the money, would be very embarrassing. There have been some life memberships extended already, and theirs have been rejected. Inasmuch as Article II, Section 8, of the Constitution definitely says that anyone who reaches the age of seventy and who has been a member of the Society for ten years is entitled to life membership, I still think it would be a rather embarrassing situation to go back to the county and tell them they have been rejected. They migbt say, "Okay! We will not pay any more dues."

THE SPEAKER: I believe there is one slight difference. I think the Section referred to says they *may* be, on application. I believe that is the word. They *may* be. That is far different from saying they *shall* be. I think we should understand that, although Dr. Day's point is well taken.

L. W. GERSTNER, M.D. (Kalamazoo): This may be a little repetitious. I was not able to hear everything.

I feel that since it is in the Constitution that there may be a life membership, and since certain gentlemen have applied to their state society or their county society to have such membership conferred upon them, be it from the viewpoint that they wish the honor, be it from the viewpoint that they feel they cannot fiancially pay it, or be it from the fact that they have been in the practice of medicine the number of years that most of them have and practiced as long as they have, I felt we would be doing a great injustice to those men, who have paid their dues this year as a gesture of friendship to the Society because they wish to maintain contact with organized medicine. I believe it would be a serious error and a mark of disrespect to those gentlemen whose names have been read, not to confer that membership at this time.

I am in sympathy; I think we need money, but I believe those recommendations should not be tabled, that those men have earned their right to that membership, and I think they should be granted that membership, even though that Section of the Constitution and By-laws may be changed later.

I think we will be in error if we do not confer those memberships on those gentlemen.

T. K. GRUBER, M.D. (Wayne): Is a motion to table debatable?

THE SPEAKER: Is a motion to table debatable? No, it is not, and I believe the motion should not have been put that way. The Chair apologizes for that. The motion should have been that action on this be delayed until next year.

C. I. OWEN, M.D. (Wayne): Did each of these men request the transfer of membership, or is this cooked up by the Society?

THE SPEAKER: I understand the secretaries of some county societies have gone out and asked the members if they wish to he put in this category. Does that answer your question?

C. I. OWEN, M.D.: No, it does not. Asking them if they want it is one thing, but actually a written application is another thing. If a man has made a written application for life membership he ought to he granted it, if he is entitled to it. If the county secretary just decided to go around and look for them and cook up some of them, that is another thing.

THE SPEAKER: The Chair is unable to answer that point. I don't know whether anybody here can answer it or not.

T. K. GRUBER, (Wayne): Point of order. A motion to table is not debatable.

THE SPEAKER: The delegate is entirely right.

W. B. HARM, M.D. (Wayne): Mr. Speaker—

THE SPEAKER: I believe under the circumstances, although I hate to do it because the attitude of this House has been, I believe, that we will not depend too much on fine points of parliamentary

procedure, that we will discuss fairly each problem that comes up so the house arrives at the conclusion it wants to arrive at. However, I believe the delegate is entirely correct.

T. K. Gruber, M.D. (Wayne): May I offer a substitute motion, that the matter be considered at the next annual meeting?

The Speaker: You have heard the motion. Is there a support for the motion? Does anybody wish to second Dr. Gruber's motion?

(There was no second.)

The Speaker: The Chair would like to hear from Dr. Spalding now.

E. D. Spalding, M.D. (Wayne): A substitute motion is not in order over a motion to table.

The Speaker: That is right.

H. L. Clark, M.D. (Wayne): Did you not say this should not have been a motion to table but should have been a motion to delay action until next year?

The Speaker: I said that, but the man has a right to make it the way he wants to.

H. L. Clark, M.D.: In that case, it is not a motion to table.

The Speaker: It is a motion to table. The Chair has accepted it, and I see no parliamentary way out except to vote on it.

A. E. Catherwood, M.D. (Wayne): While it is not debatable, I wonder if it is possible to withdraw the motion.

The Speaker: I think it would be. All in favor of Dr. Holmes' motion, as chairman of the Committee, that this action be taken—

"The Reference Committee on Constitution and By-laws recommends to the House of Delegates that action on this resolution be tabled." That is the motion. The Chairman so moved and it was seconded. I will read it once more. "The Reference Committee on Constitution and By-laws recommends to the House of Delegates that action on these resolutions for Life Membership be tabled. The Chair so moves."

C. I. Owen, M.D. (Wayne): That is a lot different than tabling the motion. That is not tabling the motion.

The Speaker: I believe that point is well taken, that this is not tabling the motion. It is deferring action, which the House has a right to do.

I will say though, in fairness to the Speaker, that I do not believe that the motion was put in that way. We will ask the stenotypist to read the motion as it was made.

(The stenotypist read the motion.)

The Chair would like to make a ruling. The Chair believes that the Reference Committee is not making a proper motion when he moves that action be tabled. He did not move that the motion be tabled. He moved that action be tabled. I believe it was an improper motion, and the ruling of the Chair will be that we cannot accept that motion, even though it was accepted at the time, and that the Chairman of the Committee should be asked to reword his motion as follows: that action on these resolutions for life membership be delayed until the next annual meeting.

R. H. Holmes, M.D.: This is not my personal motion. This is a motion of the Committee. If you desire, even though it is not quite proper, I believe, I will be very glad to poll the Committee at present and ask if they are willing to have that change.

Dr. Springer.

R. A. Springer, M.D. (St. Joseph): I am willing.

R. H. Holmes, M.D.: Dr. Breakey.

R. S. Breakey, M.D. (Ingham): The Committee went into this at some length, and for various reasons it was the sense of the Committee, individual and collective opinion, that this motion be tabled. If it is a question of wording, the sense of the Committee report cannot be altered.

R. H. Holmes, M.D.: Dr. Cooksey. Is Dr. Cooksey here? (Absent)

Dr. Babcock, are you willing to have that changed?

W. W. Babcock, M.D. (Wayne): It was originally Dr. Cooksey's motion, and I feel, as Dr. Breakey does, that the intent was that the motion be tabled.

R. H. Holmes, M.D.: I am very sorry, Mr. Speaker, to be unable to change it. That is three to one.

The Speaker: The Chair has made a ruling. The ruling is that it is an improper motion. The Chair does not believe that a member may make a motion and a motion to table that motion at the same time.

Therefore, the Chair rules that it is an improper motion and he was in error in accepting it, and he asks for a new motion.

R. H. Denham, M.D. (Kent): I move that this be referred back to the Committee and that they report at the evening session.

The Speaker: The motion is that this matter be referred back to the Resolutions Committee and that they report at the evening session. Is there a second?

H. L. Clark, M.D. (Wayne): I second it.

The Speaker: Is there any discussion?

C. I. Owen, M.D. (Wayne): I would like to offer an amendment to that motion, that they be instructed to determine from the local county representatives who presented the resolution whether or not they had written applications for membership, or whether they were cooked up by the secretary of the society.

The Sepaker: If I understood Dr. Owen correctly, he wishes that the Committee be instructed to find out, if possible, whether or not these memberships are real applications, or whether the names were simply sent in by the secretaries. Is that the point, Dr. Owen?

C. I. Owen, M.D.: That is right.

The Speaker: Is there a second to that amendment?

(The motion was seconded by Dr. Ho of Clinton County.)

W. B. Harm, M.D. (Wayne): I can speak for Wayne County. Our secretary, in accordance with the By-laws and Constitution of this Society, went through the list and found the names of the men who were qualified. He then called these men to tell them of their rights, and asked them their desire on the matter. That is only right, and it is only the duty of the secretary. Our secretary was very efficient in my mind in doing this, because most members of our Society do not know the Constitution and By-laws. He informed them of their rights and asked them their desire. Our members did not write the applications beforehand. That should not be expected of them.

The Speaker: Thank you, Dr. Harm. Is there other discussion of the amendment?

L. W. Day, M.D. (Hillsdale): Speaking of the three applicants that I listed, each of those was a verbal request, not a written request. We have other members of our society over seventy years of age, who are entitled to life membership. We have not requested it and their names have not come before the House of Delegates.

The Speaker: If I heard you correctly, Dr. Day reports that in his county these were verbal requests, not written applications.

E. D. Spalding, M.D. (Wayne): I move that this be put over one year.

(Cries of "No.")

The Speaker: Dr. Spalding, there is a motion to refer, and an amendment to that motion.

E. D. Spalding, M.D.: My motion takes precedence.

The Speaker: Just a minute! I think if Dr. Spalding could name the day next year, he probably is in order. A motion to postpone to a certain date takes precedence over a motion to refer, amend, or postpone indefinitely. It may be done only by offering the time. I think that covers it.

Is there a second to Dr. Spalding's motion?

F. A. Weiser, M.D. (Wayne): I second it.

The Speaker: Did you wish to name the day, Dr. Spalding?

E. D. Spalding, M.D.: The next annual meeting.

The Speaker: All right. Do you want to offer an amendment to your motion now that it be postponed until the next annual meeting instead of a certain day? The rules say definitely that it must be to a certain day.

E. D. Spalding, M.D.: I made it for a certain day. The motion has not been put.

The Speaker: But the Chair has to accept it. If your motion has preference it has to be according to rules. Your rules are that it must be a certain day. Do you want to make your motion that it be postponed to the first day of the next annual session or the second day? The Chair will accept that.

E. D. Spalding, M.D.: The first day.

The Speaker: The motion is that this matter be postponed until the first day of the next annual session of the House of Delegates.

F. A. Weiser, M.D. (Wayne): Second the motion.

Voice: It is the original motion.

The Speaker: I beg your pardon, but it is not. Is there any discussion on this?

L. W. Day, M.D. (Hillsdale): I disagree with Dr. Spalding on that issue. At this time next year the complexion of Section 8, Article III of the Constitution will be entirely different than it is today. I think these men are entitled to due recognition under Section 8, Article III, as it stands now, not next year.

H. L. Clark, M.D. (Wayne): I believe that we are doing a decided injustice to these men if we defer this until next year. They are entitled to certain things, according to the Constitution and By-laws, and we have no business refusing them to them from a pecuniary standpoint. The remark that there were 1300 men in the service whose dues would be paid in 1947 I believe is incorrect, because many of these men came back before, and their dues are deferred only for the first year, if my understanding is correct. So many of those men will be back and paying their dues for '47. We certainly owe something to these men who have helped to carry on the job while the other men were in the service.

W. B. Mitchell, M.D. (Kent): The question was asked whether these applications were made for life membership. In our society they were not. However, each man was called on the telephone and asked whether he wished to accept life membership or not. Four of our members refused to accept the life membership, saying they could pay their dues. However, the other eleven wished to accept life membership. I do not think we should refuse them at this time.

The Speaker: Is there further discussion?

R. S. Breakey, M.D. (Ingham): Dr. Day brings out a very pertinent point that came before the committee, that these 59 applicants have fulfilled the requirements of this Section. It does not mean that that includes the total number who possibly migbt be eligible, and this Section may be changed.

There is now in this subsequent committee report, the Committee of Reference, a resolution pertaining to the changing of this Section, as Dr. Day points out. The Committee was mucb concerned as to what would happen to another man or other men who might or are now eligible for this life membership. If this section is changed, then 59 men will be made life members, after having been members of the State Society for only ten years, simply having reached the age of seventy, not for tenure of service but on the age basis and with a relatively short membership.

Now if this section is changed we shall do an injustice. I am in accord with what Dr. Day said, and Dr. Clark. There are at present three life members. It is proposed to give life membersbip to 59 more and, if this is changed, deny it to over 340. It is merely a question of what kind of injustice we want to do.

The Speaker: Is there further discussion?

W. B. Harm, M.D. (Wayne): I had not heard anything about the change in By-laws. When the Chairman was asked, he said it was purely for financial reasons. If a change in the By-laws coming up?

The Speaker: I will answer that, Dr. Harm. I think the motion is here. A resolution was brought in by Dr. Thorup of Berrien, that this Section 8, on page 81 of your By-laws, of your Handbook, referring to Life Members, be deleted. I said By-laws, and that is not correct. It is in the Constitution.

If you will look at the end of the Constitution, page 85 of the Handbook, Article XIII, Amendments, you will see that the Constitution may be amended but a resolution to amend the Constitution has to be held over for one year before it can be discussed

or acted on. Therefore, this resolution is already in. It will he acted on next year by the House of Delegates, regardless of what action is taken on these present applications for life membership.

May I say just one thing more? We have at present, as I understand it, three life members. There are applications for an additional 59. There are possibilities of future applications, perhaps next year, of at least 350.

So it amounts to this. The three are already elected, and we cannot change that. Next year, if you act on this motion and elect these, you will have 62 life members, with the possibility that the Article may be changed next year before the others are accepted.

Does that clarify the situation? It is a question of what you want to do.

R. J. Armstrong, M.D. (Kalamazoo): I would like to support the opinion that the injustice would he to the 59 and not to tne 350. In our county the secretary took the list of the membership and picked only those who seemed unlikely to pay their dues. In fact, some pressure was brought on certain members to bring these dues up to date so they could be sent in as potential candidates for life membership. In at least one instance, the individual member paid those dues.

I am informed by a delegate from a neighboring county that the same thing was done in his county. It is a matter in many cases of losing these members entirely, who are old. They will simply be practicing physicians who are not members of the State Medical Society. These names have been presented. Dues have been paid in some cases under difficulty. I think it would be a serious injustice not to put this through as intended.

H. L. Clark, M.D. (Wayne): I would like to take issue with Dr. Breakey on the length of membership. I happen to know that a number of these men have been members for thirty or forty years. It is not ten years only. The By-laws state that if they have been members ten years, they are eligible. I know that Curlett, for instance, and Panzner and a number of these people have been members for a good many years—and several others.

The Speaker: Is there further discussion?

Alfred LaBine (Houghton): Our men were solicited, and certainly no secretary would solicit a man for life membership in our wonderful society if he has only been in ten or eleven years. I think he would use more discretion. Our men have been in over forty-five years.

I feel that insofar as the Constitution has not changed, you cannot on one hand issue a $25 a year assessment, and throw out this and throw out that. I believe the Society should give these men what they have coming. If you wish to change the Constitution for next year, that can be done. I think the secretaries of the society will be aware of that fact and they won't go out soliciting as they have this year.

The Speaker: Is there further discussion?

C. I. Owen, M.D. (Wayne): This Committee should study each name, through the county representative. There may be some that deserve it and that should not be turned down—maybe half of them. We ought to find out.

Eugene Osius, M.D. (Wayne): I would like to ask Dr. Holmes to repeat again his figures on the cost to the Society. If I understood correctly, he said $15,000. Sixty members do not figure up to $15,000. It is closer to $1800. Are you including the possible 350?

The Speaker: Will Dr. Holmes answer?

R. H. Holmes, M.D.: I think the gentleman misunderstood me. I said a spot survey indicated there were better than 400 eligible for this life membership. If I may correct one thing, there is no "shall" connected with this; it simply says they may. So please don't forget. What I said about 400 applies. It would mean a loss each year to the Society of $14,800, not for the 59 alone.

George Waters, M.D. (St. Clair): It would seem to me that inasmuch as the Constitution and By-laws has not been changed it is perfectly legitimate to give these men life memberships. If you do not do that, as has been said before, many of these men are going to be cut off from any contact with their State Medical Society, men who have practiced thirty and forty years.

It seems to me that it is petty business to deny them this at that time.

The Speaker: Is there any further discussion?

W. B. Mitchell, M.D. (Kent): In reference to the number of years in practice and the number of years they have been members of our Society, our eleven men whose names have been presented, the lowest number of years in practice is forty. The highest number of years in practice is forty-nine. If they want to speak about the number of years they have been in the Society, there is something to shoot at. Forty-nine is the highest. I think they are entitled to life membership.

(Calls for the question.)

The Speaker: Are you ready for the question?

It is before the House. I was going to call on the Secretary to tell us a little background on this, but if you want the question—whichever you say.

(Calls for the question.)

The Speaker: The motion is that action on this life membership be postponed until the first day of the next annual session. All in favor say "aye" (no one); opposed. The motion is lost.

I believe before that we were considering an amendment, an amendment to the motion that was made to refer this back to the Committee. I don't know that I can word the amendment exactly, but it was to refer it back to the Committee with instructions to get complete information about these applicants. That was seconded.

Is there discussion now on this amendment? All in favor of the amendment say "aye"; opposed. The amendment is lost. We will now vote on the main motion, which is that this matter he referred back to the Reference Committee on amendments to the Constitution and By-laws for further study and report at the meeting tonight. Is that correct?

Is there discussion on this motion?

S. L. Loupee, M.D. (Cass): I think our minds are pretty well made up on what we should do with this motion right now. Why defer it? There will be plenty of work tonight. Let's settle it now.

The Speaker: Is there any further discussion on this motion? The motion is to refer back to the Committee for further study and report tonight. All in favor say "aye"; opposed. The motion is lost.

We are now ready for a new motion, which may be made by the Chairman of the Reference Committee, I think, first if he wishes, or by anyone else in the House.

L. W. Gerstner, M.D. (Kalamazoo): I move that the names mentioned for life membership in the Michigan State Medical Society be accepted.

L. W. Day, M.D. (Hillsdale): I second the motion.

The Speaker: You have heard the motion that these applicants for life membership be elected to life membership. Is that correct, Dr. Gerstner?

L. W. Gerstner, M.D.: Yes.

S. L. Loupee, M.D. (Cass): I wish that the Chairman of the Committee would read that list. It was stated that there were 59 of them. Fifty-nine did not appear in the list he read. There were 29 or 30 in that list.

The Vice Speaker: He did not read the Wayne list.

The Speaker: Do you have the Wayne list? The delegate has requested that the Chairman read the list of applicants for life membership.

Dr. Holmes will read the list.

R. H. Holmes, M.D.: This, through stenographic error, was appended to the other list. I apologize for overlooking it. I shall read first the list for Wayne County, which has thirty members, thirty applicants.

BRUCE ANDERSON	WILLIAM J. JEND
JOSEPH H. ANDRIES	G. B. LOWRIE
ROBERT BEATTIE	WILLARD MONFORT
NOAH ARONSTAM	JOHN B. MORTON
W. E. BLODGETT	R. JOHNSTON PALMER
HARRY J. BUTLER	WALTER G. PATERSON
MARIA B. COOLIDGE	C. F. PEQUEGNOT
DUNCAN A. CAMPBELL	CHARLES A. REINBOLT
HENRY W. CADIEUX	E. O. SAGE
JAMES H. DEMPSTER	ROBERT SHAW
H. C. EMMERT	W. J. STAPLETON
WILLIAM F. HAMILTON	R. S. TAYLOR
JOSHUA HANSER	W. E. TYSON
A. HUGHES	A. B. WICKHAM
J. P. JAEGER	WALTER J. WILSON, SR.

(Dr. Holmes then read the list of applicants from other counties, as it appears on page 107).

I would like to say just one word for the Committee. We have put in a lot of strenuous sessions, trying to do what we thought was best for the Society, and there were a lot of other small angles involved that probably mean nothing in considering the whole affair, but there are a few other things that I think should he mentioned, just so you realize in some of these counties they have even as high as half of their membership seventy years of age. That means that county society's financial program is going to be cut in half.

E. A. Oakes, M.D. (Manistee): I would like to have a point of information. Will you ask the Secretary to give us the background of where this all started?

The Speaker: Dr. Oakes requests that the Secretary discuss the background of this. Dr. Foster.

The Secretary: That section in Article III was put in the Constitution two or three years ago with a view to liberalizing the requirements for emeritus membership. Emeritus membership requires fifty years of practice and twenty-five years of membership. There was a sizable group of people in the State Society who had come within a very short distance of achieving that objective, and it was the wish at that time of the Committee studying the Constitution and By-laws that there should be some liberalization so that a category could be created for those persons not able to attain emeritus membership.

The next membership in line is that of retired membership, which means that a man must be out of practice, and so it was assumed at that time that the age of seventy, with ten years of membership, would probably adequately cover it. Apparently it was not recognized then that the trend toward longevity was here and there was no knowledge apparently of the percentage of men in the Medical Society who were near or about to attain the age of seventy. So this was put on the books, and there were only about three who had availed themselves of this category of membership until the certifications came in this year, and it came before The Council at its meeting on Monday that this list was growing rapidly. We were asked to certify in the executive office some seventy-five for this.

Then it became apparent that there was an economic problem involved, and so a survey was made of the doctors of Michigan, and we found that 12.8 per cent of the doctors of Michigan are seventy or in the process of becoming seventy this year—12.8 per cent.

Some societies, as has been mentioned, have as high as over 50 per cent of their members. This is more apparent outstate than in Detroit, where I presume there is a preponderance of younger men. Most of the outstate societies are running well over 10 per cent of their members who are eligible for this membership.

The Council, being very cognizant of the feeling of economy and the question of finances, simply wants to invite to the attention of this House the fact that there was an economic phase to this thing if all of the men who were eligible for this membership felt that they should avail themselves of it especially when certain county societies had cleared their rolls of all such eligibles, the total would approach 500.

One of the county secretaries called me last night and said "If this is accorded this year then the Constitution cannot be changed next year, because we did not realize that it was necessary for us to clear our rolls of everybody over seventy, and if those societies who have done it have their members accepted, then the same principle should be accorded to the societies in the state, so that we, too, next year can bring in applications."

Now, 12.8 per cent of our present membership of 4,656 is not 400 but 558.

So it was the thought of the Committee, and I believe it was the feeling of The Council, that if this were held in abeyance this year, and this paragraph were changed to accommodate those men, such as Dr. Mitchell mentioned, who had been members a sizable number of years, and who were deserving of some honor, that then a new section might be created that would care for those men for whom this section was originally designed.

The Speaker: Thank you, Mr. Secretary.

T. K. Gruber, M.D. (Wayne): Dr. Holmes said that if enough of these societies put all of their members who were eligible on the life membership list they would lose a lot of dues in their own society. That statement is not according to the Constitution and By-laws, which say: "He shall have the right to vote and hold office but shall pay no dues to the State Society."

Then it is up to the county society if they want to pass a resolution that they do not collect dues in the county society. We haven't done that in Wayne. Maybe other county societies have. That won't cut down our income.

The Speaker: I didn't just hear the last part.

T. K. Gruber, M.D.: I said that the statement here does not say that they shall not pay dues in their county society, only in the State Society. It is then up to the county society to determine whether they want to collect dues from the member or not.

Eugene Osius, M.D. (Wayne): I should like to say a few words about this. I am happy to be a veteran, a recipient of the remission of dues for the last three or four years. I wish to say that I as well as any of my colleagues in the same position, as evidenced by the resolution last night, appreciate this most thoroughly.

I feel that since the Constitution reads as it does about these members who are over seventy and have put in the time and paid the dues that they have, it is in a sense a sort of contract. I think this Society has always stood for living up to its word and to its contract. We have had too much breaking of contracts in the last twelve years. I think that it is about time there is a step taken in the other direction, and that men again are taken exactly at the meaning of their words, and that their words are made good and kept good.

I listened with interest to Dr. Foster's analysis of the possible loss, and I would like to point out that this loss was not inconsiderable, and at the present time we can use the money and use it probably better than we did some years ago. Nevertheless I would like to point out that the views of this Society have been the same over a period of quite a number of years. When everything else has gone up, I feel that if it is necessary, to stick to our word, the dues should be raised to $15. I would be perfectly willing to pay that; I as an individual and as a veteran would be willing to pay. Let's stick to what we promised.

The Speaker: Is there further discussion?

C. F. Brunk, M.D. (Wayne): I would like to take issue with Dr. Breakey's statement and the analysis that we would probably lose 500 members. I think it is a very questionable proposition as to whether that By-law ought to be changed. Personally, I don't think it should be. I may not be a delegate next year, but if I am, I certainly will not vote to delete that By-law. I think it is a good one and we ought to carry on. The younger men can carry this Society, and if it is necessary we will increase our dues. That will be the proper thing for us to do, and give these men that opportunity.

H. H. Riecker, M.D. (Washtenaw): May I ask if this Committee had in its hands the applications of these men for life membership, as the Constitution states? Does this Committee have in its hands the written application of these men who wish to have life membership?

R. H. Holmes, M.D.: All we have, Dr. Riecker, in some cases is simply a resolution by the delegates. Some go ahead, for instance: "Whereas, the Michigan Society has conferred upon this candidate this membership," and all in proper form. We have no original applications from them. I think in most cases there were no such things as written applications by the men involved.

H. H. Riecker, M.D.: I would like to ask the Chair to make a point of order of this, because it is in the Constitution.

The Speaker: Just one minute please. The Chair has been asked a question.

If you will refer to page 81 in the Handbook, Section 8, Life Members, it reads as follows:

"A physician who has attained the age of seventy years or more and maintained an active membership in good standing for ten years or more in the State Society may, upon application and recommendation of his County Society, be transferred to the Life Members' Roster by election in the House of Delegates. He shall have the right to vote and hold office but shall pay no dues to the State Society. Requests for transfer shall be accompanied by certification by the Secretary of the State Society as to years of membership in good standing."

I don't believe that anywhere in that section it says this application shall be in writing, and I believe the Chair is correct, and if not I can be corrected on it, that the regular routine has been followed in these cases. The regular routine is this: They are recommended by their county society. The county society clears their names through our Secretary; that is, as to their credentials and the length of time they have been in the Society and so on. Then the only writing that is presented is the resolution presented here by the delegate who proposes the name. That has been routine in this and in previous years, and in all types of special membership so far as I know. Is that correct?

So I believe Dr. Riecker's point was not well taken.

S. L. Loupee, M.D. (Cass): I was interested in the discussion on this motion of the House. It is true that this organization cannot afford to go back on its contract with these men. We must absolutely stand by our contract, but let's read this provision in Section 8 more carefully and see just what it does mean.

". . . in good standing for ten years or more in the State Society may, upon application and recommendation of his County Society, be transferred to the Life Members' Roster . . ."

It doesn't say he shall be. It is still optional with this group that we have here today, whether it is for the welfare of the individual, whether it is for the welfare of the people of the state, whether it is for the welfare of this county or of this group. It is still in the hands of this group to decide.

I asked purposely to have all this list reread, to get all these 59 names before us, and in the process of reading I heard a remark close by, "Enough wealth is represented there to buy the whole Cadillac Hotel," and I think possibly they could buy a room for several days.

At any rate, it is perfectly obvious that a considerable number of this list do not actually need this at all. They are perfectly able to pay their bills and would be willing to do so, except that somebody has called them up and said, "Don't you want to get into this? It would be a nice time. It is an honor, and you would have no more dues to pay."

Let's be fair with the Society and with everybody else. Let's exercise our right, here and now, to decide whether these men shall or shall not.

It seems to me that if we want to spend a little more time, and if we will send this resolution back to the Committee and ask them, carefully, considerately, to filter this list, there are certainly many, as Dr. Day says, who are entitled to it. I would be glad to see every one of those men put on the life membership list, but there are a great many of these fifty-nine who don't want it, who wouldn't sign an application for it, and who will not be at all disturbed if they do not get it.

L. W. Gerstner, M.D. (Kalamazoo): These men have already been approached by the county society. If you are going to filter these men, you are going to filter them on the basis of reputation. You are not filtering them on the basis of their economic ability to pay. That does not enter into this constitutional paragraph, and it has no right to enter into the discussion here. I think the only thing we should be allowed to discuss is the paragraph itself and its manifestations. I don't believe we should have a right to say, "Well now, Jack Jones, maybe he is able to pay, and therefore we should not allow him this honor." We should put it on some other basis than that.

I feel, Dr. Loupee, that you are out of order in speaking as you did. In my society there is no man that we have so honored who has not deserved the honor, and the society in open meeting has voted on each man individually, that he shall be so honored by the State Society.

Now if the State Society says, "Well, we may do it," I think each one of those men will consider it a personal affront if he is refused this honor.

S. L. Loupee, M.D. (Cass): Dr. Gerstner said, "Let's stick to the wording of Section 8." I will submit to you that I definitely did stick to the wording of Section 8, and it says that we may, and I say that this organization, not the county society, according to this wording, remains and still has the right to decide. It is up to the State Society. It is not up to the county society. All of the things which enter in the welfare of this Society should be taken into consideration at this moment, and one of the things which enter into the welfare of the Society at this particular moment is the economic consideration.

I don't think we are doing anything wrong. I can't see it at all. I think the members here can fairly decide and be fair to all the men.

George Waters, M.D. (St. Clair): It is true that we would lose the dues of these fifty-nine members, but we are losing sight of the fact that we are taking in new members each year. We have a group of new members coming in each year which I think might offset the ones that we are giving this membership to.

S. W. Insley, M.D. (Wayne): From a little personal knowledge, I happen to notice that there were a large number of the men whose names were read who have been members of this Society for twenty-five years or more. That being so, I don't see why we cannot welcome most of the names read off.

On the other hand, I agree with Dr. Loupee that there should be a loophole left open this afternoon, either for a further report tonight or for some piece of machinery set up so we will be in position next year to make a change if we have to. If you recall, amendments to the Constitution have to lie over for a year, and this is the Constitution and not the By-laws. Take the names, if

you like. The majority have been in for a long time. But I think that in the meantime we can give it further study and adopt something else next year.

W. B. Harm, M.D. (Wayne): Mr. Chairman, it is hard to get away from this discussion. I move the previous question.

(The motion was seconded.)

The Speaker: The motion is that these fifty-nine applicants whose names you have heard read shall be elected to life membership. All in favor say "aye;" opposed. The motion is carried.

S. W. Insley, M.D. (Wayne): I did not have a chance to make an amendment to the motion just read. Is there any provision yet this morning to have this matter given further study?

The Speaker: No, sir, except this—I believe there is one way to have further study if you wish. I am not sure that it will hold water. The motion to accept the report of the Reference Committee as a whole has not been made. That will be a very fine point.

S. W. Insley, M.D.: Mr. Chairman, under the order of New Business, cannot a motion be put in to the effect that the Committee on Constitution and By-laws start to work this year on the change of this section?

The Speaker: That is not necessary. It has to hang over until next year anyway.

S. W. Insley, M.D.: You have to have it printed somewhere during the year.

The Speaker: That is correct. That is provided. You will find it on the bottom of page 85, at the end of the Constitution and By-laws.

R. H. Holmes, M.D.: The Reference Committee on Amendments to the Constitution and By-laws, of the Michigan State Medical Society, moves that the amended report be adopted.

The Speaker: The motion is that the report of the Reference Committee as a whole, as amended, be adopted.

The motion was seconded and carried.

XII—6 (j). REFERENCE COMMITTEE ON RESOLUTIONS

The Speaker: The next order of business is the supplementary report of the Reference Committee on Resolutions, Dr. Walker.

Roger Walker, M.D.: I have to report on the resolution brought in by Dr. Cooksey in reference to nurses: "Inasmuch as there exists today a critical lack in graduate nurses in the State of Michigan and throughout the nation;

Inasmuch as the schools of nursing have only one-tenth to one-half the enrollment they should have to meet current needs; and

Inasmuch as this shortage of nursing care may lead to a reduction of existing hospital beds, the supply of which now available does not meet the public demand; and

Inasmuch as the Michigan Council on Community Nursing and all local component councils which have representation from organized medicine, the State Hospital Association, Organized Nursing, and the public have been given the responsibility of studying this problem and instituting ways and means of overcoming this situation; and

Inasmuch as the Michigan State Nurses Association, in co-operation with the Michigan State Hospital Association, has already established minimum personnel practices including wages, hours of work, vacations and other matters directly concerned with personnel practices; and

Inasmuch as organized nursing has already developed training programs for subsidiary workers to assist in the care of patients to give the best possible distribution of trained nurses; and

Inasmuch as committees of organized nursing are studying all phases of nursing education to attract young women into this field; therefore be it

RESOLVED, That the House of Delegates of the Michigan State Medical Society instruct the Nursing Committee of the Michigan State Medical Society to cooperate with the existing nursing agencies concerned with this problem; and be it further—"

(This is a correction the Committee has made.)

RESOLVED, That this resolution be referred to the Committee on Nurses Training Schools for study and report to the Council.

I recommend the adoption of this resolution.

(J. S. DeTar, M.D., the Vice Speaker, assumed the chair.)

(The motion was seconded by Arch Walls, M.D., of Wayne, and carried.)

XII—6 (l). ASSESSMENT ($25.00)

Roger Walker, M.D.: I have another resolution that was brought in yesterday and sent back for further study.

Whereas, Much progress has been made by the Michigan medical profession in effecting wider distribution of quality medical care; and

Whereas continued public education is necessary to continue and extend programs which have made for the better health of all the people such as we have begun; and

Whereas, $10 was appropriated in 1944 and $10 in 1945, and $25 in 1946 for the purposes of public education and all has been allocated except a reserve fund for exigencies; and

Whereas, A necessarily comprehensive program has been scientifically prepared and developed to meet the greater problems anticipated in 1947; and

Whereas, The public education-public relations program has shown great progress and will continue to grow, and financial provision must be made in advance to meet the requirements of the contemplated program, therefore, be it

RESOLVED, That a per capita assessment of $25 be levied for the year 1947 for purposes of public education and public relations.

The Committee recommends approval of this resolution, with the deletion of this sentence: "Whereas, in 1947 the need will be more acute because it is a legislative year."

I move the adoption of that resolution with that correction.

The Vice Speaker: You have heard the resolution. Is there a support?

(The motion was seconded by R. W. Teed, M.D., Washtenaw.)

T. K. Gruber, M.D. (Wayne): I believe the resolution states a per capita of $25 assessment. Are we going to present that to World War veterans, too?

Roger Walker, M.D.: It was my understanding that it was an assessment last year and would be considered as dues this year.

The Vice Speaker: I believe that is a rule of The Council. The assessment is considered a part of the dues so far as veterans and members are concerned.

Is there any other discussion? If not, all in favor say "aye;" opposed, "no." The motion is passed.

Roger Walker, M.D.: I have a new resolution that was sent in last night.

XII—6 (m). PROCEDURE FOR PRESENTATION OF SPECIAL MEMBERSHIP TO HEADQUARTERS

Whereas, The presentation of candidates for special memberships in the Michigan State Medical Society is ordinarily made by the various delegates, and

Whereas, The customary procedure of presentation of these candidates is time-consuming and repetitious, therefore, be it

RESOLVED, That a Committee of the House of Delegates be appointed to deal with all recommendations for special memberships, and be it further

RESOLVED, That all such recommendations for special memberships be presented to the chairman of this committee prior to the first meeting of the Annual Session of the House of Delegates for presentation in toto by the Chairman of this Committee at the Annual Session of the House of Delegates, and be it further

RESOLVED, That due and satisfactory notice of this procedure be given all secretaries of all county medical societies by information in the Secretary's Letters and by printed notice in the Journal of the Michigan State Medical Society for two succeeding months prior to the Annual Session of the House of Delegates of the Michigan State Medical Society.

The original resolution read "four months." The Committee felt that two months was sufficient to bring in or send in the names proposed.

I move the adoption of this resolution.

(The motion was seconded by W. R. Young, M.D., Van Buren, and carried.)

XII—6 (n). RE: CLOTURE

Whereas, This House must be concerned with many and various interests of the constituent physicians hereby represented, and

Whereas, Upon too frequent occasion the business of the House has been unnecessarily retarded by undue dissertation relative to one matter only, and

WHEREAS, It is desirable that the proceedings of the House be expedited to permit the expression of thought of the many interested and that the human tendency to elaboration should be controlled by definite regulation and

WHEREAS, Such precedent has been established in civil legislative bodies and many medical societies by the establishment of cloture for limitation of the privilege of the floor, therefore, be it

RESOLVED, That reports of committees, special or otherwise, and presentation or discussion of all other business be limited to ten minutes upon the occasion of each separate recognition by the Speaker with the exception of the Speaker's address, the President's address, the Annual Report of The Council, and such essayists before this House as may appear by invitation, and the response of the President-elect, and further be it

RESOLVED, That at the expiration of this ten-minute period the recipient of the floor may be granted an additional five minutes upon the "per voce" vote of the members of the House in attendance.

The Committee disapproves of this resolution, and I move the rejection of this resolution.

I might give the reason we disapproved of this resolution. There was quite a discussion about it. We felt that this was a democratic organization, and there were times when everybody should have an opportunity to express himself as he saw fit, within reasonable limitation. Under parliamentary rule, the Speaker can limit any discussion as he sees fit to do. We felt that it was not necessary arbitrarily to put a time limit.

(Dr. Ledwidge, the Speaker, resumed the chair.)

THE SPEAKER: You have heard the motion to not adopt this resolution as offered. Is there a second to the motion?

C. S. CLARKE, M.D. (Jackson): I second the motion.

THE SPEAKER: Is there discussion?

R. H. PINO, M.D. (Wayne): I am deeply appreciative to Dr. Breakey for bringing this up, one of the most important resolutions that has been introduced at this meeting.

The time that is allotted to the subject should be, if necessary, as long as the subject is important. I can see that there are some things that can be passed very readily. There are other things that cannot be. There are other things that simply cannot be understood in a very short time.

I want to call to your attention two occasions when time was given, and how glad we are that time was given. One was back at the time when a special meeting, a whole special meeting of the delegates was called at Flint, for the purpose of discussing the subject matters brought by Dr. Luce at that time. Then on the same subject, a few years later, a whole Sunday afternoon was set aside, in this very room, when I was privileged to give two hours to a discussion along with the presentation of material that it had taken weeks and months to prepare and give to you right as you sit here now, in the form that we gave last night or yesterday, in order that it might be definitely understood, and then because every detail, which only time and experience could supply, was not given, the whole House was condemned, though it passed it later, by different ones saying they had not been given all the facts. They had been given, of course, all the facts and only such facts as could be given with the experience and with the knowledge at hand, but they had been given all that could be accumulated at that time, and without the time given there would have been no action, and today we would not have the Michigan Medical Service, which obviously has helped us somewhat.

It is my opinion that if, following the meeting at Flint, Dr. Luce had prepared material which was available and presented it the following year, Michigan Medical Service would have been started years before it was, and the Washington fiasco and the Supreme Court decision would not have taken place, and the American Medical Association would have been in far stronger position than it is now.

I want to call your attention to another thing. Last year I introduced a resolution on this subject. We were held that night in the Reference Committee until one-thirty in the morning, and we were gotten up at eight o'clock in the morning, the next morning, to discuss that, for one primary reason. The resolution could not possibly cover this great big subject, and it was that night that Dr. Breakey talked a good deal about it, and I had him in mind very much when I wrote that article that I read yesterday, because at that time Dr. Breakey said, and he stuck to the point, that the chiropodist was only a manicurist. Now when it is true that some people have an attitude of that kind toward something, it is obviously necessary to take those points and elaborate on them, because they are very important. These people are really practitioners of medicine and surgery.

I want to call your attention to another thing, and I think this is most important. The very weakness of the influence of the American Medical Association is due in part to the very small amount of time that is allotted in sections to the discussion of important things that come up in section meetings. We meet and we have long hours of discussion in sections on scientific things, and devote ten minutes or half an hour to the business of that section. The result is that when material goes from the section to the House of Delegates of the American Medical Association, it is so poorly presented that one time when I attended a meeting of the House of Delegates they actually laughed at the material that came through. It hadn't been finished. It hadn't been talked through.

As an example of not thinking through—and I would just as soon this would go into the record—when Morris Fishbein says to the people of America, for us doctors of America, that the Sister Kenny treatment has no value, instead of saying we do not know that it has value but we will investigate and we will report to the people of America, I want to say that he is doing one million dollars worth of damage in our public relations, and he has done it.

You can repeat that, if you wish.

The Speaker says for me to repeat it. All right. I am saying that at the time that the question came up about the Sister Kenny treatment, if only Dr. Fishbein had said, "We do not know but we will investigate and find out and report to you," he would have done us one million dollars' worth of good instead of one million dollars' worth of damage.

The people look to us for leadership, and we have to think through, and we can't just speak out quickly, without thinking through. I know you do not want important matters brought to you that have not been thought through. Men do not come from over the state to many meetings of a Commission, as they have this year, and not expect their Chairman to bring a comprehensive report of what they have gone over.

I want to call to your attention, in this material that we bave given out, that there are several sections in that, that have to do with various subjects, such as the clinical laboratory technicians, physical medicine, and so on. We did not have time to work that up carefully. Those are only suggestions, but my attention was called to it very sharply last night, but very kindly, that it was a very poor outline. We know that. It is only suggestive. It is an example of not having it complete.

I want to say to you that a great deal of sincerity has gone in and expense in the preparation of that. Personally, it cost me $200, and I do not expect to ask the State Society for a cent of it. It cost me much more than $200.

It happens that when Judge John Curran, the Irish patriot and member of Parliament, made the empassioned statement in Dublin in 1808, that "Eternal vigilance is the price of liberty," which Dr. Breakey fervently quoted, Judge Curran was speaking on the right of the people to be heard. I wonder if Dr. Breakey had looked that up.

I believe that medical associates will be as important as medical service, and if it is not so in five years, I shall apologize for the length of my presentation and for the resolution, but not until then.

R. S. BREAKEY, M.D. (Ingham):* I do not propose to enter into debate with Dr. Pino nor prolong this discussion unnecessarily further. I move the question.

THE SPEAKER: The motion is:

The Reference Committee on Resolutions does not approve this resolution and moves that it be not adopted. All in favor say "aye;" opposed. The motion is carried.

XII—6 (o). RE: MHS AND MMS

ROGER WALKER, M.D.: I have one more resolution referred to us last night, with reference to the Michigan Medical Service:

Whereas, The Michigan Medical Service and the Michigan Hospital Service, jointly, known to the public as the Michigan Blue Cross Plan, is the largest voluntary organization offering a prepayment medical and hospital insurance service in the United States and includes over one-fourth of all subscribers to such plans in the United States, and

Whereas, The Michigan Medical Service and Michigan Hospital Service, the Michigan Plan, because of its size and the publication of its activities, has become a recognized leader of such plans by the public, and

Whereas, Any failure or division in the Michigan Plan at this time could only encourage and perhaps promote the passage of Federal Social Legislation, to the detriment of the health of the people of this nation, and therefore becomes of paramount importance to every doctor in Michigan, therefore, be it

RESOLVED, That every effort be made to further the successful mutual co-operation of Michigan Medical Service and Michigan Hospital Service.

Mr. Speaker, the Committee recommends the adoption of the REVISED resolution after consultation with the sponsors of the original form of the resolution.

I move the adoption.

THE SPEAKER: You have heard the motion. Is there a second?

L. G. CHRISTIAN, M.D. (Ingham): I second the motion.

THE SPEAKER: Is there discussion on this motion?

T. K. GRUBER, M.D.: Will you read the resolution again?

(Dr. Walker reread the resolution.)

(The motion was carried.)

ROGER WALKER: I move the adoption of the report as a whole.

(The motion was seconded by George Waters, M.D., St. Clair, and carried.)

THE SPEAKER: Are there further resolutions, or is there otber new business?

VIII—19. MSMS VIEWPOINT RE NURSING SITUATION

WILLIAM BROMME, M.D. (Wayne): It has just been brought to my attention that currently the convention of the American Nurses' Association is being held in Atlantic City. Therefore, it seems not inappropriate to acquaint the Michigan delegates to

the American Nurses' Association convention with the point of view expressed by the resolution adopted this morning.

The resolution is as follows:

WHEREAS, The House of Delegates of the Michigan State Medical Society has stated its position regarding the problem of nursing care, and

WHEREAS, Delegates from Michigan nursing are currently attending the Annual Convention of the American Nurses' Association; be it therefore

RESOLVED, That the Michigan delegates to the American Nurses' Association be instructed promptly as to the point of view of the Michigan State Medical Society regarding the nursing problem.

THE SPEAKER: The resolution will go to the Reference Committee on Resolutions.

S. L. LOUPEE, M.D. (Cass): I move the suspension of the rules and the immediate consideration of the resolution.

C. L. WESTON, M.D. (Shiawassee): I second the motion.

THE SPEAKER: I am not so sure about suspension of the rules. It takes a two-thirds vote.

All right. You have heard the motion that the rules be suspended and we consider this resolution immediately. All in favor of this motion say "aye;" opposed. The motion is carried, and we will consider this resolution at this time. Is there discussion?

J. H. LAW, M.D. (Wayne): Are we in position yet to transmit to the Nurses' Association our views? It seems to me from our action this morning the resolution was referred back to the Nurses Training School Committee for report to The Council. I am wondering if we have a concrete view to transmit to our delegates at the meeting of the Nurses' Association.

THE SPEAKER: I am not sure I got your point.

J. H. LAW, M.D.: I wonder if our viewpoint is clarified, other than that we recognize the problem. I don't believe we have a definite recommendation to offer to the nurses at this time.

THE SPEAKER: Dr. Law makes the point, if I understand it correctly, that the resolution that was passed was to refer this matter to the Committee on Nursing Training Schools for further study and report. Is that correct?

J. H. LAW, M.D.: Yes.

THE SPEAKER: And that is all that has been done, really, officially, so that we really have no action to report, other than the fact that it has been referred to a special committee for study.

S. L. LOUPEE, M.D. (Cass): May I ask the Chairman of the Nursing Committee what progress they have already made and whether there is any prospect of immediate report, or whether it is to be delayed long?

THE SPEAKER: I believe Dr. Oakes is chairman of that Committee. Is Dr. Oakes in the room?

E. A. OAKES, M.D. (Manistee): There has been no action taken by this Committee. None of the other committee members are present at this time. I do not believe we can do that in a short time. We have had no definite recommendation, except what was given lact night, which has been brought up before the House again today.

S. L. LOUPEE, M.D. (Cass): I, therefore, move that action on this resolution *be tabled.*

(The motion was seconded by several delegates and carried.)

THE SPEAKER: Are there further resolutions?

IX—2. PROPOSED AMENDMENT TO CONSTITUTION

L. G. CHRISTIAN, M.D. (Ingham): This is an amendment to the Constitution, to try to clarify the thing that we argued about this morning.

WHEREAS, Section 8 of Article III of the Constitution is originally intended to recognize period of service and membership in the Michigan State Medical Society and

WHEREAS, Section 6 requires fifty years in the practice of medicine regardless of attained age of the individual, and

WHEREAS, Ten years of membership, regardless of age, is a relatively short period of membership, therefore be it

RESOLVED, That Section 8 of Article III be amended to read: "A physician who has attained the age of seventy years or more and maintained an active membership in good standing for twenty-five years or more."

We are merely deleting "ten" and substituting "twenty-five."

THE SPEAKER: Thank you, Dr. Christian. This matter is routinely referred to next year's House of Delegates, according to Article XIII, Section 1.

Is there further business to come before the House?

If not, the chair would like to make two announcements.

(Announcements.)

(The meeting adjourned at twelve-thirty o'clock.)

Tuesday Evening Session

September 24, 1946

The meeting convened at eighty-forty o'clock, P. L. Ledwidge, M.D., the Speaker, presiding.

THE SPEAKER: We are somewhat delayed for the reason that we haven't had a quorum. I believe there is a quorum here now.

Is the Chairman of the Credentials Committee ready to report?

J. J. O'MEARA, M.D.: I have the credentials of eighty-seven members, properly certified, which is more than enough to form a quorum, 50 per cent of which is not from any one county.

THE SPEAKER: If there is no objection from the House, this report will be accepted as the roll call for this meeting.

We have two or three things to finish.

If you will please turn to page 92 of your Handbook, Section 7 (1) on the matter of new business, that section states that no new business shall be introduced in the last meeting of the Annual Session without unanimous consent of the House.

There has been a request by two members to offer amendments to the Constitution. This will constitute only the reading of amendments, which are automatically referred to next year's House of Delegates. No time will be consumed. No action can be taken and there will be no discussion. Is the House willing to listen, giving unanimous consent to listen to these two short amendments?

E. A. OAKES, M.D. (Manistee): I so move.

(The motion was seconded by H. F. Dibble, M.D., Wayne, and carried unanimously.)

THE SPEAKER: We will have those two resolutions then, one by Dr. Loupee and one by Dr. Robert Baker of Oakland. Dr. Baker, will you present your amendment?

IX—3. PROPOSED AMENDMENT TO CONSTITUTION

R. H. BAKER, M.D. (Oakland): This is simply to clarify the discussion we entered into at some length this morning. I did not feel, and some others around me did not feel, that the resolution presented by Dr. Christian completely covered the points in our discussion. This is not quite the resolution that Dr. Loupee will present to you. It will go on the books for discussion next year, with the hope that out of the three resolutions an adequate compromise can be arrived at to meet the situation.

We have two sections in Article III of the Constitution, one dealing with emeritus membership and one dealing with life membership. The qualifications are somewhat different. I have chosen in my resolution to combine both of them with the qualifications, so that Article III, Section 6, will be amended to read as follows:

"Emeritus Membership—Any physician who has been in practice fifty years, or has attained the age of seventy years, and who has maintained a membership in good standing for twenty-five years, may, upon written application, and upon recommendation of his county society, and by election in the House of Delegates, become a member emeritus. A member emeritus shall be required to pay annual dues to the State Society not in excess of ten dollars and be relieved of paying all assessments. He shall be entitled to all the benefits and privileges of membership."

In part of the same resolution I would delete Section 8 of Article III, which deals with life membership.

I am combining both the qualifications of life membership and emeritus membership.

THE SPEAKER: Thank you, Dr. Baker. That will automatically be referred to next year's House.

Dr. Loupee of Cass County.

IX—4. PROPOSED AMENDMENT TO CONSTITUTION

S. L. LOUPEE, M.D. (Cass): My resolution refers to Article III, Section 8, the one we discussed this afternoon, and to that alone. It shall read as follows:

"Life Members—A physician who has attained the age of seventy years or more and maintained an active membership in good standing for twenty-five years or more in the State Society may, upon his signed application, filed in the office of the State Society, and approved by his County Society at a regular or special meeting thereof, be transferred to the Life Members' Roster by election in the House of Delegates. He shall have the right to vote and hold office but shall pay no dues to the State Society. Requests for transfer shall be accompanied by certification by the Secretary of the State Society as to years of membership in good standing."

It provides for twenty-five years instead of ten, and it provides for a stricter certification. The applicant must sign the application himself. The application could be on a form which is furnished by the State Society, and there are certain other restrictions.

I just pass it for consideration.

THE SPEAKER: Thank you, Dr. Loupee.

We will proceed with the reports of the Reference Committees.

Is there a supplementary report from the Reference Committee on Officers' Reports?

On Reports of the Council?

On Reports of Standing Committees?

On Reports of Special Committees?

On Amendments to the Constitution and By-laws?

On Resolutions?

XII—6 (p). RE: PRIORITIES FOR DOCTORS OF MEDICINE IN PURCHASE OF AUTOMOBILES

Whereas, The veterans of World War II are impeded in their efforts to re-establish themselves in the practice of medicine by lack of adequate automobile transportation, and

Whereas, Doctors of Medicine who carried the increased burden of medical care during the war years find their automobiles worn to the extent that they no longer give satisfactory and dependable service, and

Whereas, Efficient and dependable transportation is necessary to the wide distribution of quality medical care, and

Whereas, Efforts to obtain priorities on new automobiles by the county societies have not as yet been successful, therefore, be it

RESOLVED, That the attention of The Council of the Michigan State Medical Society be called to this situation and The Council be urged to take such action as it deems advisable on the state level to obtain priorities for Michigan Doctors of Medicine for the purchase of new automobiles.

ROGER WALKER, M.D.: The Committee considered this quite considerahly at a meeting this evening and approves most heartily of this resolution and moves its adoption, with every hope of success and Godspeed.

I move the adoption of this resolution.

(The motion was seconded hy R. W. Teed, M.D., Washtenaw, and carried.)

ROGER WALKER, M.D.: I move the adoption of the complete report of the Committee on Resolutions.

(The motion was seconded by L. G. Christian, of Ingham, and carried.)

THE SPEAKER: Thank you, Dr. Walker.

(Recess.)

XIII. Elections

THE SPEAKER: We shall proceed with the next order of business, which is the elections.

XIII—1. COUNCILOR—FIRST DISTRICT

First on the list is the election of Councilors. There are four vacancies. The first vacancy is in the First District. You all remember that there is a ruling on this, that nominations can be made only hy delegates from the district which that Council represents.

Nominations are now in order for Councilor of the First District.

WILLIAM BROMME, M.D. (Wayne): For the First District, I nominate for re-election the present Councilor, Dr. Umphrey.

THE SPEAKER: C. E. UMPHREY, the incumbent, has been nominated to succeed himself. Are there other nominations?

W. B. HARM, M.D. (Wayne): I move that the nominations be closed and the tellers instructed to cast the unanimous ballot.

(The motion was seconded hy W. W. Bahcock, M.D., of Wayne, and carried.)

THE SPEAKER: I would like now to appoint the tellers. We will appoint as tellers: C. L. Weston, M.D., Shiawassee, Chairman, D. B. Wiley, M.D., Macomb and W. W. Babcock, M.D., Wayne.

XIII—2. COUNCILOR—FOURTH DISTRICT

THE SPEAKER: The next vacancy is in the Fourth District.

D. W. THORUP, M.D. (Berrien): It is my pleasure and privilege to inform you that it is the unanimous opinion of the delegates of the Fourth Councilor District that the present incumbent, R. J. HUBBELL, of Kalamazoo, can most adequately represent us as Councilor of the Fourth District. Therefore, I nominate Dr. Hubbell to succeed himself as Councilor of the Fourth District.

THE SPEAKER: Dr. Hubbell, the present incumbent, has been nominated to succeed himself, the unanimous choice of the district. Are there other nominations?

S. L. LOUPEE, M.D. (Cass): I move that the nominations be closed and the Secretary be instructed to cast the vote for Dr. Hubhell.

(The motion was seconded by L. G. Christian, M.D., Ingham, and carried.)

XIII—3. COUNCILOR FIFTH DISTRICT

THE SPEAKER: The next vacancy is in the Fifth District. Nominations are in order for Councilor for the Fifth District.

R. H. DENHAM, M.D. (Kent): The delegates of the Fifth District are unanimous in wishing to congratulate the President in appointing the present incumbent to succeed Dr. A. B. Smith, who resigned, and we desire to place again the name of J. DUANE MILLER as a candidate for Councilor of the Fifth District. Dr. Miller is a veteran of World War II, served well, and deserves to help carry on the business of this Society.

THE SPEAKER: Dr. J. Duane Miller, the present incumbent, has heen unanimously nominated by his district to succeed himself. Are there other nominations?

If not, the Chair will entertain a motion that the nominations be closed.

H. F. DIBBLE, M.D. (Wayne): I move that the nominations be closed and the Secretary be instructed to cast the unanimous ballot for Dr. J. Duane Miller to succeed himself.

(The motion was seconded and carried.)

XIII—4. COUNCILOR SIXTH DISTRICT

THE SPEAKER: The next vacancy is in the Sixth District. Nominations are now in order.

C. L. WESTON, M.D. (Shiawassee): The Sixth District would like to present the name of R. C. POCHERT, Owosso, the present incumbent, to succeed himself.

THE SPEAKER: Dr. Pochert has been nominated by unanimous vote of the Sixth District to succeed himself. Are there any other nominations?

(Upon motion made and seconded, the nominations were closed and the Secretary was instructed to cast the unanimous ballot for the election of Dr. Pochert.)

XIII—5. DELEGATES TO AMA

THE SPEAKER: Next is the election of delegates to the American Medical Association. You will note that there are three vacancies this year. Therefore, we have to nominate at least three candidates. Nominations are now in order.

ROGER WALKER, M.D. (Wayne): It is my pleasure to place in nomination a man who has heen active in the conventions, and who I think will represent the State of Michigan well at the American Medical Association convention, W. B. BARRETT.

THE SPEAKER: Dr. Wyman B. Barrett has been nominated.

L. G. CHRISTIAN, M.D. (Wayne): I ask your indulgence in the remarks I am about to make. I wish to support the nomination of Dr. Barrett, and say that he is a worthy successor of our dean and our chief, Henry Luce. It will take all of the efforts of the combined delegation of the AMA to make up that loss. Dr. Luce, as you know, has through the years carried the torch for the very thing that you heard about tonight. It was he who, in 1935, went to Cleveland and was kicked around by the AMA. It was he who in 1938 went to San Francisco and asked for a Bureau of Information and Public Relations in Washington. It was he who sponsored, and Dr. Gruber activated, the attempt to muzzle Fishbein. So it has been through the years that Dr. Luce has represented you, and he has represented the practitioner of medicine, not only in Michigan but throughout this country. He has been a driving force. He has had what it takes, and I may say that he was feared by the AMA. They called him a radical as recently as six months ago, and you know he is not that.

I feel that no happier choice could be made to succeed my chief and our dean than in Dr. Barrett. I hope you will elect him. *(Applause)*

THE SPEAKER: Are there further nominations for delegates to the American Medical Association?

S. W. INSLEY, M.D. (Wayne): I would like to have the very distinct pleasure and privilege tonight of offering in nomination a man from our state, a man whom I think I have known as long, if not longer, than practically any other man on the floor tonight, as I have known him from the time he was an intern at Harper Hospital, and then went up north to practice medicine. Today the whole country very, very much admires and respects him. He is a man who I think commands the respect of every man on the floor of this House. He has once heen elected as President of this Society.

I would like to do this not only out of pure, old-fashioned knowing-of—and I am a sort of a father of that—but also because I think I have demonstrated that I have a very, very deep interest in seeing that Michigan does the best it can, both locally as well as nationally. He is a man who, when the going gets rough, is going to vote for Michigan and what he believes to be right, rather than to be swayed by what maybe some other groups has in mind.

I take great pleasure in offering in nomination tonight as a delegate, and not from Wayne County but from up north, CLAUDE R. KEYPORT.

THE SPEAKER: Dr. Claude Keyport's name is offered in nomination.

W. B. HARM, M.D. (Wayne): I would like to take this opportunity, hoth on behalf of the delegates of Wayne County and on behalf of the general practitioners of Michigan, to second the nomination of Dr. Keyport, who is one of the old regulars of Michigan. Lately, in an article in the Medical Economics, some man from California said you could tell anyone from the House of Delegates of the American Medical Association by standing in the back of the hall and looking at the back of their heads. Michigan has had five men who, from the back of their heads, didn't look very good, but until this time the inside has been darned good, to put it mildly, and Dr. Keyport has been one of them.

It is a great pleasure for me, as a general practitioner and a member of the Wayne delegation, to second the nomination of Dr. Keyport.

THE SPEAKER: Thank you, Dr. Harm. Are there other nominations?

R. H. BAKER, M.D. (Oakland): It is with great pleasure that I step up here to place another nomination before you for Delegate to the American Medical Association. We have had to make one change, unfortunately, with the retirement of Dr. Luce, and we certainly cannot get along without our very genial delegate of past experience. Incidentally, he is very helpful to the Chair up here on matters of parliamentary procedure. I want to place in nomination our old friend, TOM GRUBER.

THE SPEAKER: Dr. Gruber's name has been placed in nomination, and the Chair would like to thank him for the help he has been in that way and in other ways.

S. L. LOUPEE, M.D. (Cass): I support the nomination.

THE SPEAKER: It is supported by Dr. Loupee of Cass.

Are there other nominations for delegate to the American Medical Association?

R. H. DENHAM, M.D. (Kent): I move that the nominations be closed and the Secretary be instructed to cast the unanimous vote for the three men who have been nominated.

R. A. SPRINGER, M.D. (St. Joseph): I second the motion.

(The motion was carried.)

XIII—6. ALTERNATE DELEGATE TO AMA

THE SPEAKER: We now have to elect alternate delegates to the American Medical Association. There are three vacancies. You will recall that this presents a little bit of a problem. These men will have to be voted on by ballot, because the one who gets the highest number of votes is senior alternate delegate elected this year. He is junior to the alternates elected last year.

Nominations are now in order for alternates.

R. S. Breakey, M.D. (Ingham): To make a nomination for any office such as we are now considering, some small explanation is probably in order. I wish to submit the name, first, and speak about the man secondly—R. H. DENHAM of Kent.

Dr. Denham has served as Senior Delegate of this State Society over a period of years almost as long as have some of the delegates, and upon the occasion of the last meeting of the American Medical Association he represented us as a delegate, in the form of an alternate for Dr. Keyport, whose eulogy you have just heard.

Dr. Denham is of a caliber which is equal, in my opinion, to that of any of the delegates already elected, and it is well that the material to supplant that which might not be there, be of equal caliber. Upon the occasion of this meeting, from my county society there are two alternates, not two originally elected delegates.

I submit that Dr. Denham's record of service in committees, as a member of this Society, and his personal integrity entitle him to the position that he now holds, that of senior alternate.

The Speaker: Thank you, Dr. Breakey. Dr. Denham's name is in nomination. We will now hear from Dr. Harm of Wayne.

W. B. Harm, M.D. (Wayne): I would like to second that nomination before any more are put in.

The Speaker: The nomination is seconded by Dr. Harm. The Speaker points out that seconds are not necessary, but they are very desirable.

J. A. Kasper, M.D. (Wayne): The name that I am going to place in nomination does not need any speech. This gentleman is known by all of you, both as an illustrious son of an illustrious father, who is not only a great physician, but in his position as President of the Michigan Medical Service he has given to this State Society and the physicians of Michigan fifty thousand dollars a year worth of free services as a businessman and an executive, for the great sum of nothing, something that you couldn't replace.

I nominate R. L. NOVY of Wayne. *(Applause)*

The Speaker: R. L. Novy has been nominated. Are there other nominations?

H. F. Dibble, M.D. (Wayne): I would like to place in nomination the name of a veteran of World War II, a man who I think could serve in this position as well as Dr. Breakey says. I am quite sure he could do as well as the rest of the men. That is C. I. Owen, better known as "Red" Owen.

The Speaker: Dr. Clarence I. Owen has been nominated. Are there other nominations?

R. S. Breakey, M.D. (Ingham): I move that the nominations be closed and the election be held.

The Speaker: The motion is that the nominations be closed and we proceed to ballot. Is there a second?

(The motion was seconded by Alfred LaBine, M.D., of Houghton.)

Will the Secretary please prepare the ballots?

T. K. Gruber, M.D. (Wayne): What I would like to know is, if every person votes, why they won't get the same number of votes.

The Speaker: That is a very good question. In such event the names will be drawn from the hat for seniority.

T. K. Gruber, M.D. (Wayne): May I suggest that, without going to the trouble of a ballot, the names be drawn from the hat, assuming each one will vote for three.

The Speaker: You make that as a motion?

T. K. Gruber, M.D. (Wayne): I make that as a motion.

The Speaker: It is moved that all be declared to have all the votes, and that seniority be determined by drawing from the hat.

E. A. Oakes, (M.D. (Manistee): I second the motion.

The Speaker: Motion is made and seconded. May the Chair refer momentarily to the rules in this connection?

May I read you the section?

"The number of alternate delegates shall equal the number of delegates to the American Medical Association. Delegates and alternates shall hold office for two years.

"At each annual election, candidates for delegates and alternates shall be nominated in number equal to or greater than the number to be elected. Election shall be by ballot. The required number of high candidates shall be declared elected."

The Chair rules that we have no right to vote that way. Election shall be by ballot.

T. K. Gruber, M.D. (Wayne): Will you read the next paragraph?

The Speaker: Yes.

"In case of a tie vote between any number of high candidates, the Speaker and Vice Speaker shall vote on the two candidates alphabetically first, each filling out a secret ballot, one of which shall be drawn at random by the chief teller. The defeated candidate shall then be paired with the next alphabetically following candidate and ballots cast in the same manner. This process is to be repeated until all ties have been resolved."

Is that enough, Dr. Gruber?

The Chair rules that there has been no tie, until there has been a vote, and that voting must be by ballot.

S. W. Insley, M.D. (Wayne): To resolve this thing, may I ask, as a matter of ruling of the Chair, that regardless of who the two might be who would lose out in the final election, there should be at least one or two members added to the nominations. Otherwise I think you are defeating part of your Constitution and By-laws.

The Speaker: No, I don't think so, Dr. Insley, because it says that the number of alternate delegates shall be equal to the number of delegates. I think this is only a question of seniority.

S. W. Insley, M.D.: You won't determine their seniority on the basis of drawing out of a hat, if you have the other way of doing it.

W. H. Mast, M.D. (Northern Michigan): Is there any reason why we have to vote for three men? Is it possible to put in a ballot with just one man's name on it?

The Speaker: Yes, it is. You can have one or two or three names.

L. W. Day, M.D. (Hillsdale): Dr. Gruber has drawn our attention to the fact that if we vote for three men, each man will receive the same number of votes, but we can have No. 1, No. 2 and No. 3.

The Speaker: That is right, Dr. Day, but the Chair feels that this vote should be by ballot, because it is perfectly possible in voting for these three men that they may not all receive the same number of votes. I know it takes a little time, but I think it is fair.

Member: Point of order. Is there not a motion before the House?

The Speaker: The Chair was asked for a ruling.

Member: The motion was made that the nominations be closed, and I don't believe there was any vote on it.

The Speaker: There are three nominations and it is necessary to fill three vacancies. The By-laws say it must be done by ballot. You may vote for one, two or three, as you please, and when the ballots are counted, the individual having the highest number of votes will be the first one elected, and he will have seniority of the Alternate Delegates elected this year.

(The ballots were cast.)

The Speaker: The question has been asked if we can proceed with the business and have the report of the tellers later. Do you wish to do that?

Delegates: Yes.

The Speaker: All right. Will you please be seated then.

XIII—7. PRESIDENT-ELECT

The next order of business, while we are waiting for the ballots to be counted on the Alternate Delegates, is the election of the President-Elect. Nominations are now in order for President-Elect.

W. D. Barrett, M.D. (Wayne): It gives me a great deal of pleasure to come up here and talk about the man that I want to propose for President-Elect. There is no question about his integrity. There is no question about his fairness. There is no question about his judgment. You have seen him in action for quite a few years. I am not going to talk long about it. You all know him. You all know him as well as I do. He is an Irishman and he enjoys an Irish joke as well on him as he does on somebody else.

I wish to present the name of P. L. LEDWIDGE, for President-Elect. (Applause)

(Dr. DeTar, the Vice Speaker, took the chair.)

The Vice Speaker: Is there a second to the nomination?

(The nomination was seconded by several delegates.)

The Speaker: Are there other nominations?

E. A. Oakes, M.D. (Manistee): I second the nomination.

S. W. Insley, M.D. (Wayne): I move that the nominations be closed and the Secretary be instructed to cast the unanimous ballot.

E. A. Oakes, M.D. (Manistee): I second the motion.

The Vice Speaker: It has been moved and seconded that the nominations be closed and the Secretary be instructed to cast the unanimous ballot for P. L. Ledwidge for President-Elect. Is there any discussion? If not, all in favor, please say "aye;"—Please rise.

(The delegates rose and applauded.)

The ballot is unanimous, and I congratulate Speaker Ledwidge on his new elevation.

(Cries of "Speech!")

P. L. Ledwidge, M.D.: Haven't you had enough?

Well, fellows, it is pleasant to think that one's colleagues consider him worthy of the highest honor that the State Society can give, especially after five years as Speaker. During this time some pretty delicate problems have come before the House.

I am sure that the action you have taken is based on friendship, rather than on my ability to serve. I appreciate that friendship more than words can tell, and I assume this high honor with gratitude and humility, and with a full understanding of the responsibility that goes with it. Thank you.

(P. L. Ledwidge, M.D., the Speaker, resumed the chair.)

The Speaker: Nominations are now in order for the Speaker of the House of Delegates.

XIII—8. SPEAKER OF THE HOUSE OF DELEGATES

E. A. Oakes, M.D. (Manistee): I think I am well qualified, having sat up in the chair for a little while, to know what some of the problems are. We had a young man up here who demonstrated his ability quite well to handle the Speaker's job. I would like to place in nomination the name of J. S. DeTAR.

The Speaker: Dr. DeTar's name has been placed in nomination.

C. H. Ross, M.D. (Washtenaw): Coming from Dr. DeTar's county, I would like to second the nomination.

The Speaker: The nomination is seconded by Dr. Ross.

R. W. Teed, M.D. (Washtenaw): I move that the nominations be closed.

The Speaker: Not yet. You will get your chance maybe. Are there other nominations for Speaker?

Roger Walker, M.D. (Wayne): I do not wish to make any other nomination, but I would like also to second the nomination of Dr. DeTar. I think perhaps I have known Dr. DeTar longer than almost anybody in the room. I endorse the nomination.

The Speaker: Thank you, Dr. Walker.

Are there other nominations?

R. W. Teed, M.D. (Washtenaw): I move that the nominations

be closed, and that the Secretary be instructed to cast the unanimous ballot.

(The motion was seconded by R. A. Springer, M.D., St. Joseph, and carried.)

THE SPEAKER: Nominations are now in order for Vice Speaker.

XIII—9. VICE SPEAKER

P. E. SUTTON, M.D. (Oakland): I rise with a great deal of pleasure to place a man in nomination that I have in mind. I have known this man a great many years. I have been a close friend as well as a very keen observer of his activities for a great many years.

During the few years it has been my pleasure to be a delegate in this House, I have also had the opportunity of observing the caliber and ability of such speakers as Phil Riley, Pat Ledwidge, Ellery Oakes, and now Jack DeTar. I believe with a great deal of conviction that the man I have in mind has all of the qualities that you and I desire to carry on the job as our previous Speaker has done.

I take a great deal of pleasure in nominating ROBERT BAKER of Pontiac.

THE SPEAKER: Dr. Robert Baker of Oakland County has been nominated.

W. B. HARM, M.D. (Wayne): In behalf of the Wayne delegation, I would like to second that nomination.

THE SPEAKER: Are there other nominations?

R. H. HOLMES, M.D. (Muskegon): This morning I, with trepidation, got up to speak. This evening I am very glad to make another nomination for Vice Speaker—LELAND HOLLY of Muskegon. Dr. Holly has been a delegate here for quite a few years, but he has been a very active man in organized medicine. Anyone who knows him, knows that he is for the organized profession. He has had a great deal of experience in the Board of Education, the Chamber of Commerce, and has had various executive and administrative jobs. As a doctor, I do not think anyone else can compare with his qualifications.

I would like to place his name in nomination for Vice Speaker.

THE SPEAKER: The name of L. E. Holly of Muskegon has been placed in nomination. Are there other nominations for Vice Speaker?

Are there other nominations for Vice Speaker?

If not, the Chair will entertain a motion that the nominations be closed.

R. H. DENHAM, M.D. (Kent): I move that the nominations be closed.

THE SPEAKER: Are the tellers ready to report on the other?

You will please pass the ballots so you can be voting by ballot on the two nominees for Vice Speaker—Robert Baker of Oakland, and L. E. Holly of Muskegon.

(Call for the question.)

THE SPEAKER: We have to decide between the two.

That is right. There was a motion that the nominations be closed.

(The motion was seconded and carried.)

Now you will vote on the two candidates.

THE SPEAKER: I will ask the Secretary to read the result on the ballot for Alternate Delegates to the American Medical Association.

THE SECRETARY: The result is as follows:

R. L. NOVY.....72 votes
R. H. DENHAM.....54 votes
C. I. OWEN.....43 votes

THE SPEAKER: According to the By-laws, all three men are elected. Dr. Novy will have seniority of the Alternate Delegates elected this year; Dr. Denham will be next in seniority; and Dr. Owen will be third.

The question has been brought up about seniority. Seniority of Alternate Delegates goes to those Alternate Delegates who were elected last year. These men are juniors to those elected last year, in this order.

If you wish their names, they are on page 26, of the Handbook. That will be Dr. H. H. Cummings will be senior. His time expires next year. Dr. Ralph Pino will be junior after that. These people come next.

R. S. BREAKEY, M.D. (Ingham): Dr. Denham was on that list last year.

THE SPEAKER: That is correct, but his term has expired. He is now a junior. That is right.

L. W. GERSTNER, M.D. (Kalamazoo): Would it be out of order to give a vote of thanks to our Secretary and our Executive Secretary for their work during the past year?

THE SPEAKER: It would certainly be in order, Dr. Gerstner, and I assure you that will be done as soon as we have finished our other business.

You may make that as a motion at this time, if you wish, Dr. Gerstner.

L. W. GERSTNER, M.D. (Kalamazoo): I move, sir, that the delegates in meeting give thanks to our Secretary and our Executive Secretary for the faithful service to this organization during the past years of service, and particularly the past year.

THE SPEAKER: Is there a second?

(The motion was seconded by H. F. Dibble, M.D., of Wayne and several other delegates.)

THE SPEAKER: You have heard the motion. It is a great pleasure for the Speaker to put it. The motion is that a vote of thanks be given to our Secretary and our Executive Secretary for their faithful and able work. All in favor say "aye"; opposed, "no." The motion is carried.

While we are waiting for the report of the tellers, perhaps I can say the things I have to say, so we may go as soon as we have this report.

I would like at this time to thank all the delegates for coming, and for their kindly co-operation in getting this work through. I would like especially to thank the Chairmen of the Committees and the members of the Committees. It seems to me that our work in committee this year has been unusually good, and I am sure that that work has shortened our work here. I thank you sincerely.

I want also to add to the motion that has just been passed my personal thanks to Dr. Foster, Bill Burns, Lynn Leet, and all the others in the executive office, for the work and the service they give is tremendous and it is certainly appreciated by your Speaker.

H. H. RIECKER, M.D. (Washtenaw): I have been forced off my seat, but very, very willingly, to express the appreciation of the Society, myself included, for the very excellent work of Dr. Ledwidge as Speaker of the House and our deep appreciation of his service to the House of Delegates through these very trying years. I cannot express in words how I feel about the fairness and the judgment you have used through these years. I have been down here two years now and I cannot find anyone who doubts your sincerity and effort and honesty as Speaker of the House of Delegates.

R. A. SPRINGER, M.D. (St. Joseph): I second that.

(The delegates rose and applauded.)

THE SPEAKER: There is a request for a speech by our newly elected Speaker, Dr. DeTar.

J. S. DETAR, M.D. (Washtenaw): To step into the shoes of Dr. Ledwidge is a job that certainly no one would aspire to, and I am certain that there is no one in this room, including myself, who feels he is capable of filling those shoes. Pat Ledwidge led this House with a sense of fairness and with an ability that I do not think can be equalled for years to come.

However, you have my promise and my pledge that with the capable help of Ed Spalding as Parliamentarian and the rest of you as assistants, I will do my very best. (Applause.)

THE SPEAKER: I don't know that there is anything else to be discussed. We will wait a minute until we get the report of the tellers.

Dr. Foster has suggested that we announce that the place of the next meeting has been determined. It will be in Grand Rapids. The exact date has not been determined.

W. B. HARM, M.D. (Wayne): I was wondering whether it would be out of order at this time to bring before the House of Delegates the services of Dr. R. S. Morrish, our President during the past year, the excellent work that he has done, stepping into the vacancy and doing the work.

I move that this House of Delegates give a vote of thanks to Dr. Morrish for his excellent work last year.

THE SPEAKER: Is there a second to Dr. Harm's motion?

ROGER WALKER, M.D. (Wayne): I second the motion.

THE SPEAKER: As I understand it—I couldn't hear very well—the motion was that we give a rising vote of thanks to Dr. R. S. Morrish for his splendid work during the year.

(The delegates rose and applauded.)

Thank you.

The tellers are now ready to report on the ballot for Vice Speaker of the House. It is as on the blackboard—

R. H. BAKER, M.D.....49 votes
L. E. HOLLY, M.D.....28 votes

According to the rules and the By-laws, Dr. Baker will be our Vice Speaker next year. He is expected to be in the front row tomorrow night.

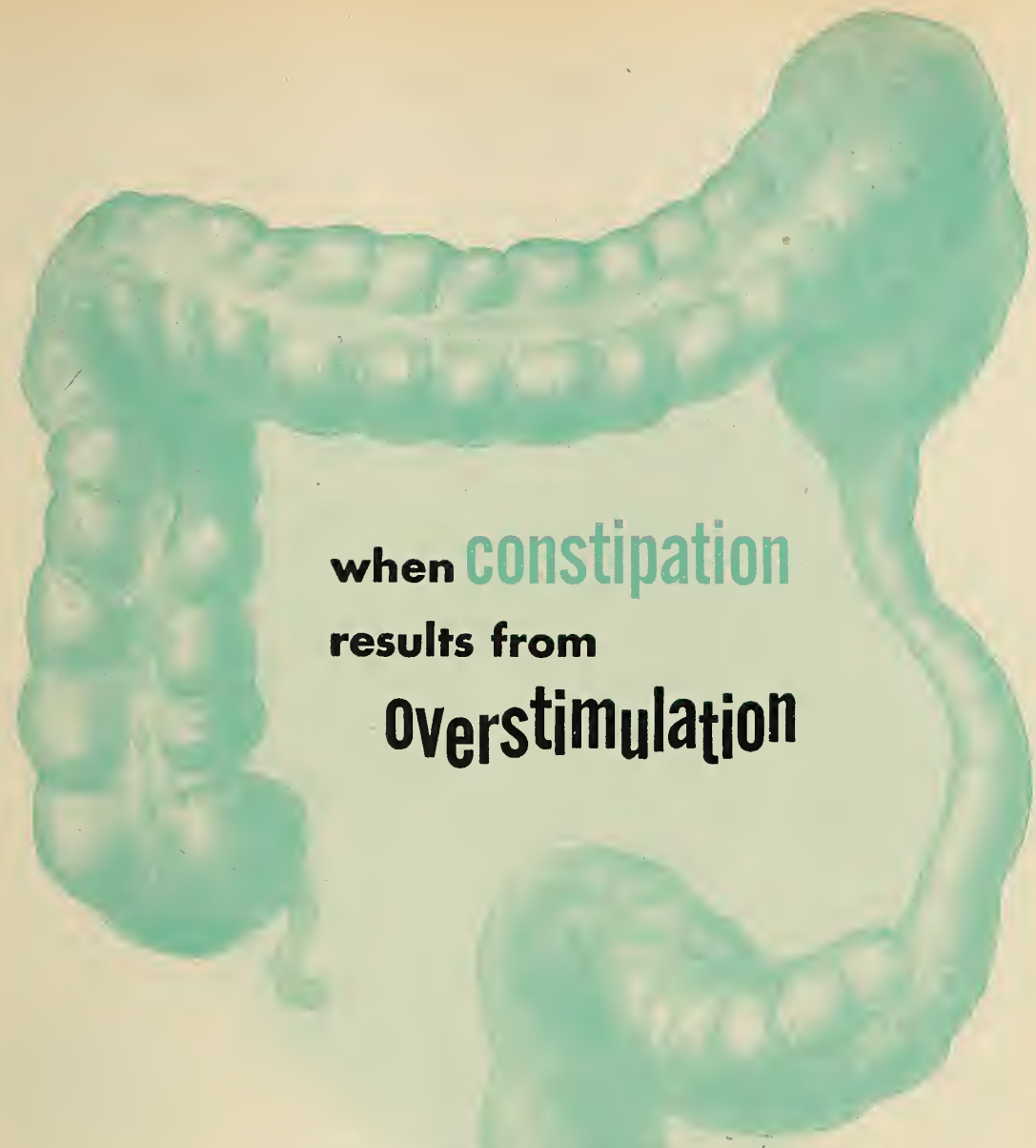
That concludes our work, gentlemen, and a motion to adjourn is in order.

(The 1946 session of the House of Delegates adjourned at eleven o'clock.)

XIV. Adjournment

STATE MEETINGS COMPARED

Visits by the executive secretary to the annual state medical meetings in Ohio and Michigan revealed some startling differences in the way these medical organizations conduct their sessions in comparison with ours. For instance, Ohio has two full days of general scientific work, and Michigan has three days of such type program. In both states the House of Delegates elects the councilors. Our method of the counties, electing their councilors is much more democratic. Ohio has an annual dinner; Michigan does not, but holds a "grand ball." Our neighbors do not go in for good times at their meetings, neither setting aside time for entertainment, like Indiana's Tuesday-night buffet supper and stag party. The meetings in Ohio and Michigan last three and four days, respectively, compared with our two days.—Editorial, *Indiana State Journal,* November, 1946.



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Michigan's Department of Health

Wm. De Kleine, M.D., Commissioner, Lansing, Michigan

MICHIGAN'S HEALTH IN 1946

The largest number of births in history and the lowest infant death rate will be Michigan's record for 1946. Judging from the first ten months, Michigan's 1946 infant death rate will be 33.51 per 1000 live births compared with the 1945 rate of 35.93. Also at an all-time low according to 10-month figures in the maternal death rate of 1.32 compared with 1.49 in 1945. In 1933 Michigan's maternal death rate of 5.55 was lower than any previous year's and it has dropped in each succeeding year.

Although no serious epidemic occurred in 1946, the general death rate increased to 10.01 per 1000 population, on the basis of ten-month figures, as compared with 9.87 for 1945. Michigan's lowest death rate in history was 9.52 in 1942.

The 1946 bumper crop of babies will top the 1943 record of 125,441. The 1946 total is estimated at 130,000 as compared with 111,557 births in 1945. This will make the 1946 birth rate 23.92 as compared to 20.53 for 1945.

Judging by the figures for the first nine months, marriages in 1946 are estimated at 78,517 with a rate of 28.89 as compared with 48,329 in 1945 and a rate of 17.78. The previous record for marriages was 51,582 in 1942.

Divorces have been steadily rising since 1938. It is estimated that they will reach 24,000 in 1946 with a rate of 8.83 as compared with 21,133 in 1945 with a rate of 7.78.

Judging by the first nine months, the ten leading causes of death will continue in the same order as in 1944 and 1945 with the exception that premature births will move from ninth to eighth, replacing diabetes. As usual, heart disease will lead all other causes of death in Michigan, with cancer second. During the first nine months there were 13.258 deaths due to heart disease against 12,625 for the same period last year. Cancer killed 5,470 persons during the nine-month period compared to 5,243 last year. Appoplexy was in the third place for the nine-month period with 3,800 deaths, followed by accidents, 2,734; inflammation of kidney, 1,907; pneumonia, 1,441; tuberculosis, 1,401; premature births, 1,254; diabetes, 1,147; and hardening of the arteries, 718.

CHANGE IN RAPID TREATMENT CENTER POLICY

The Michigan Rapid Treatment Center has been expanded from 100 to 150 beds and will now accept for treatment any patient in the following categories referred by a licensed physician: Primary and Secondary syphilis, early latent syphilis of less than four years duration who have received less than twenty arsenical and twenty heavy metal injections. The treatment in the Center usually takes ten to eleven days. Physicians can make reservations for patients by calling the Medical Officer in Charge, Michigan Rapid Treatment Center, 1135 E. Catherine St., Ann Arbor, phone, 2-6541.

TULAREMIA IN SOUTHERN MICHIGAN

From October 1 through December 9, nine cases of tularemia were reported from southern Michigan. During October and November the State Health Department laboratory in Lansing ran forty agglutination tests. With reference to this laboratory confirmation of clinical diagnosis, it is important to remember that the agglutination titer rises slowly and may not be positive until the third or fourth week of the disease.

MEDICAL RESEARCH AND TRAINING FELLOWSHIPS

The United States Public Health Service, Federal Security Agency, announces that approximately 120 one-year fellowships in medical research are open to men and women who are graduate science students. These fellowships are part of the program of the National Institute of Health, a unit of the Public Health Service.

The National Cancer Institute, which operates as a division of the National Institute of Health, also has funds to train approximately 30 physicians in the diagnosis and treatment of cancer. Under a federally financed program, doctors wishing to specialize in this field may be appointed as trainees and be assigned to authorized non-federal, non-profit institutions in various parts of the country.

Applications for fellowships and traineeships should be sent to the Director, National Institute of Health, Bethesda, Maryland.

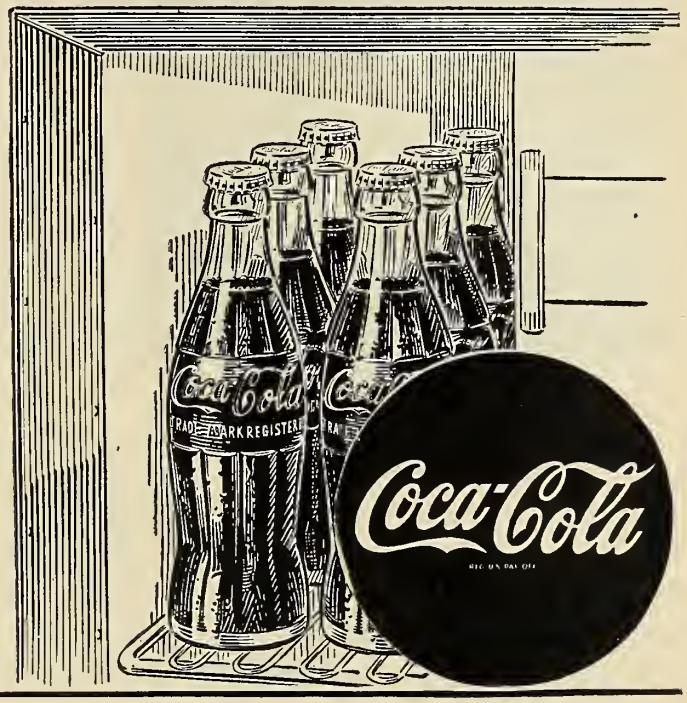
DEATHS FROM TUBERCULOSIS IN MICHIGAN, 1936-45

In ten years the population of Michigan has increased by slightly less than 400,000 persons, but during the same period the number of tuberculosis deaths has decreased by 342. The rate has gone down in a more striking way, from 41.34 to 32.35. The proportionate mortality is a figure that is commonly used in place of the death rate for the non-census years and it will be noted that the number of deaths from tuberculosis in relation to the number of deaths from all causes has not changed significantly for the state as a whole during this period.

The most striking improvement in tuberculosis control, as judged by deaths from tuberculosis, is to be found in the 15 counties in the Upper Peninsula. The number of deaths from tuberculosis for 1945 is approximately half the number of deaths occurring ten years ago. The decline has been consistent and continuous.

(Continued on Page 120)

Have a Coke



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DEATHS FROM TUBERCULOSIS

(Continued from Page 118)

Likewise, the decline in proportionate mortality has been continuous and striking. Detailed studies of groups of counties in the Upper Peninsula indicate that certain large counties have not shared in this continuous decline in the number of deaths.

The sixty-seven county area in southern Michigan, represents, as it has for many years, the most favorable tuberculosis situation in the state. The population in this part of the state has increased slightly but the deaths have decreased from 763 to 575 and except for the year 1945, there has been a continuous steady decline. The decrease in the death rate and in the proportionate mortality are likewise noticeable.

Wayne county is today Michigan's chief problem in tuberculosis control. There has been no significant decrease in the number of deaths from tuberculosis in that county for the past ten years. The death rate has fluctuated from fifty-eight to forty-four, but the decline is not continuous and not significant. Likewise, the proportionate mortality remains relatively fixed.

INCIDENCE OF COMMUNICABLE DISEASE

Disease	Nov. 1946	Nov. 1945	7 year median
Diphtheria	38	81	45
Gonorrhea	877	1035	922
Lobar Pneumonia	64	57	171
Measles	131	628	628
Meningococcic Meningitis	6	16	12
Pertussis	743	628	780
Poliomyelitis	106	21	20
Scarlet fever	512	545	593
Syphilis	1403	1295	1064
Tuberculosis	448	401	459
Typhoid fever	1	6	6
Undulant fever	16	21	7
Smallpox	1	1	2

ELIGIBILITY FOR EMIC

With the enactment of the "Armed Forces Leave Act of 1946" under which enlisted men are paid for the number of days of accumulated leave at the time of their discharge, questions have arisen regarding the eligibility of wives and infants of discharged servicemen under the Emergency Maternity and Infant Care program.

The date of separation or discharge of the serviceman from the armed forces is the date used in determining eligibility under the EMIC program. The number of days accumulated leave for which the enlisted man is paid at that time in no way affects the actual date of separation or discharge. Therefore, if the wife of a serviceman becomes pregnant after the date of separation, she is not eligible for maternity care under the program.

(Continued on Page 122)

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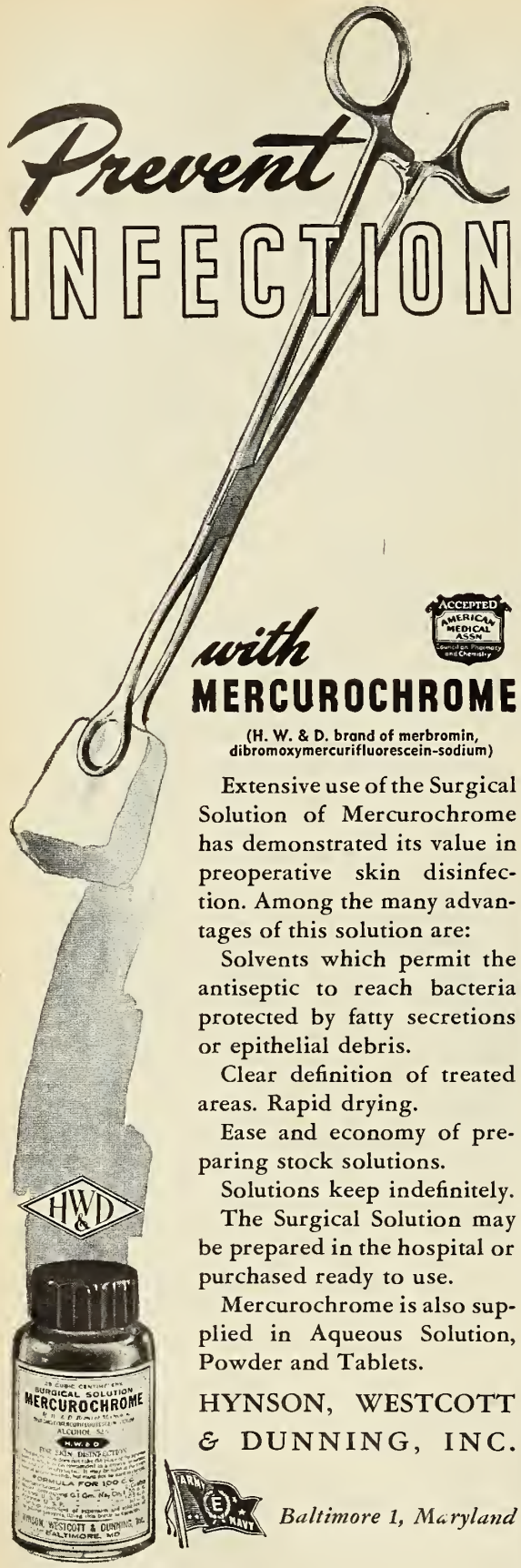


(Continued from Page 120)

INDUSTRIAL HEALTH OPENS NEW DISTRICT OFFICE

A new district office of the Bureau of Industrial Health has been established in Wayne County with headquarters at the Wayne County Health Department in Dearborn. Frank E. Macaulay, who has been in charge of the Pontiac District Office, was placed in charge of the Wayne County District Office starting December 1. Frederick McDermott will take over the Pontiac Office.

NEWS OF PERSONNEL

Ernest Cook, M.D., who was formerly in public health work at Pontiac, and who has been in local health work in Mississippi and Florida, returned to Michigan to become director of the Shiawassee County Health Department effective November 1.

* * *

William B. Wild, M.D., became director of the Barry County Health Department November 1. Prior to coming to Michigan, he was director of the health department for Richland County in Mansfield, Ohio, for six years.

MICHIGAN DOCTORS

Michigan doctors have spent $60,000 of their own money in a radio program of public health education. They established nine Rheumatic Fever Diagnostic Centers, twelve Cancer Treatment and six Cancer Detection Clinics. A state-wide study of Child Health Care was made at their own expense. They contributed $112,000 to the Michigan Foundation for Medical and Health Education. They provided free care to veterans with service-connected disabilities by a doctor of the veteran's choice. They established Michigan Medical Service, enrolling one-seventh of the population; and Michigan Hospital Service, supplying hospital care to one-fifth of their population. Some record!—Editorial, *Indiana State Journal,* November, 1946.

SO YOU THINK IT'S NEW!

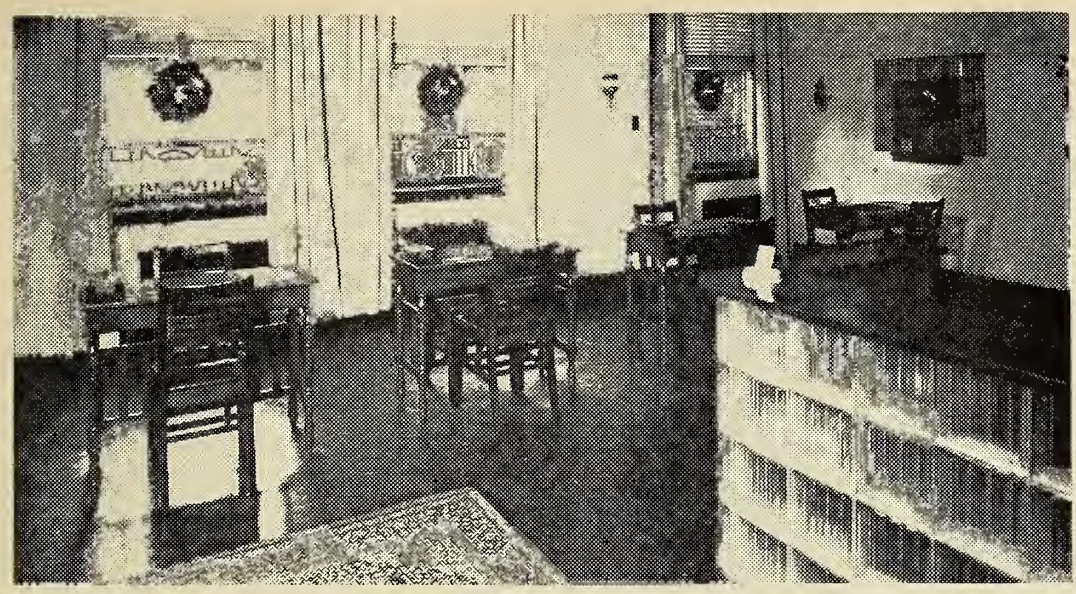
The Cesarean operation, often said to be named after Julius Caesar, was performed four hundred years before the Emperor's birth.

More than 4,000 years ago the Babylonian king, Hammurabi, established socialized medicine and fixed the fees of physicians according to the means of the patient.

Four hundred and fifty years before Christ the Greek physician, Hippocrates, tied off arteries during an operation and sewed up wounds with a needle and thread.

In 1500 B.C., the citizens of Thebes were complaining that there were no longer any good old family physicians. Every one was a specialist. "The practice of medicine," writes Herodotus, the Greek historian, "is so divided among them that each physician is a healer of one disease and no more. All the country is full of physicians, some of the eye, some of the teeth, some of what pertains to the belly."

—Editorial, *Hygeia,* February, 1946



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Correspondence

WAR DEPARTMENT
OFFICE OF THE SURGEON GENERAL
WASHINGTON 25, D. C.
November 25, 1946

Dr. L. Fernald Foster, Secretary
Michigan State Medical Society
2020 Olds Tower
Lansing 8, Michigan

My dear Dr. Foster:

Thanks for your letter of the 18th of November. I sincerely appreciate the resolution which was passed by the House of Delegates of the Michigan State Medical Society, concerning the status of the Surgeons General. Please express to those delegates my personal appreciation.

With reference to the resolution concerning medical veterans priority in purchase of surplus supplies, that priority has been set up and in operation for quite some time. It applies to all veterans, not just medical. Our office, more than a year ago, did its best to make available to medical and dental veterans lists of its surplus property so that they could determine what they need and make application to the War Assets Administration. I am including a copy of one of these lists. This is the third list that has been issued.

Concerning your second resolution, your House of Delegates was misinformed as to the ratio of medical officers called to active duty per thousand. Actually, at the peak of operations, when the war was on in Europe and the Army had its maximum of 47,000 doctors the ratio of doctors to Army strength was a little less than 5.5 per thousand. At the Battle of the Bulge the strength was 45,000 doctors. This strength was brought up to 47,000 after some 2,000 ASTP students were brought in. We had to reduce the medical personnel to 32 doctors per thousand beds in our general hospitals in all the theaters. This included the commanding officer and his executive. Many of these hospitals were expanded to 1500 beds and I am sure you will agree that was not too many doctors to give care to that many battle casualties, who frequently arrived by the train load. In our future planning we will use 5.5 doctors per thousand men in our peacetime Army and for future mobilization if the strength of the Army is better than 500,000. We are organizing a Medical Service Corps to take the place of the Medical Administrative Corps, the Sanitary Corps, and the Pharmacy Corps that did such a splendid job during the war, in assisting the medical officers. We expect to use three of these allied scientific men per thousand to do jobs that will not require the services of a doctor.

I should like to express to you, as Secretary of the Michigan State Medical Society, my appreciation for those members of your organization who served in the

(Continued on Page 126)

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*Cohen, A., Trommer, P., and Goldman, J., J.A.M.A., 130:265, 1946.

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DETROIT 14 MICHIGAN

(Continued from Page 124)

armed forces, as well as those who carried on in the teaching jobs in our medical schools and made it possible to maintain the Army Specialized Training Program. I should also like to express my appreciation for the valuable research and scientific data that was made available to the Army during the war by those who stayed at home.

S/Norman T. Kirk
T/Norman T. Kirk
Major General
The Surgeon General

STATE MEDICINE FOR BRITAIN

Both supporters and opponents of the Wagner-Murray-Dingell compulsory medical insurance bill which Congress failed to do anything about either way this year will watch with interest an experiment Great Britain soon will launch. It is a program of national medical care passed by the house of commons in July and now on the verge of receiving the house of lords' approval.

Britain has had state medicine for the last 35 years, although on a much more limited scale than that proposed in the new plan. American doctors who have witnessed the program in operation uniformly have reported that the effect on those employed by the government frequently was a deadening one. Assured of a certain, if modest, income from the government, many doctors ceased to have any interest in new developments, being content to dole out pills and cathartics to a section of the public that had little choice but to accept them. The old individual patient and physician relationship naturally has fallen off.

But despite the shortcomings of the old British medical program, the Labor government is now about to put into effect a still more radical plan. It is frankly a Socialist program, one of the important planks in the Laborites' platform, and should be carefully examined with that point uppermost in mind.

The British act provides for free medical and hospital service for everyone, regardless of occupation or status under the social security law. . . . Under the act all hospitals, their properties and equipment, will become the property of the government, together with any endowments they may be receiving. . . .

There are many factors which should discourage any tendency to set the British experiment up as an example for the United States. First is the fact it is being carried out by a Socialist government as part of a Socialist program and doubtless will evolve into something more radical than it is at present. The point is, of course, that it is questionable whether a nation can have "a little bit of Socialism" without having to commit itself to going all the way. Also, it must be noted that the large scale participation in Blue Cross plans in the United States and the existence of community-sponsored hospital and medical programs for the needy—both of which programs are being continually expanded—have provided adequate medical and health services for an ever-increasing number of Americans within the framework of our system.

—Extracts from editorial, *Grand Rapids Press,* October 19, 1946.

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* * *

"Progeria with Nanism" appeared under Clinical Notes in JAMA of November 16. The article is authored by Robert C. Moehlig, M.D., Detroit.

* * *

Streptomycin is now produced in sufficient quantities to permit the Civilian Production Administration to release this drug for general distribution.

* * *

Past-Presidents J. H. Curtin, J. T. Connell, and D. R. Brasie were honored by the Genesee County Medical Society at a dinner December 3 at the Flint Country Club.

* * *

H. T. Sethney, M.D., Menominee, is president, E. C. Eisele, M.D., Ironwood, is president-elect and W. S. Jones, M.D., Menominee, is secretary of the Upper Peninsula Medical Society.

* * *

E. S. Parmenter, M.D., of Alpena has retired from private practice to become Director of No. 4 County Health Unit with headquarters at Rogers City, as of December 1, 1946.

"Pediatric Allergy" was the subject of Bret Retner, M.D., New York, speaking before the Michigan Allergy Society at its January 16 meeting in Detroit. Many MSMS members interested in pediatrics and allergy attended this interesting meeting.

* * *

Veterans Administration is operating twenty-four former Army and Navy hospitals to meet the growing need for hospital space. The authorized hospital capacity of Veterans Administration has passed the 100,000-bed mark for the first time in history.

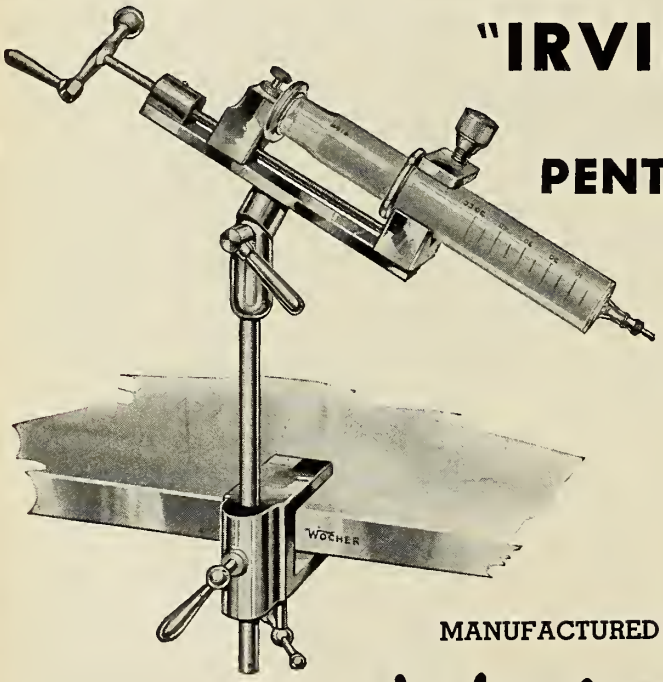
* * *

"Painless Obstetrics or Adoption Procedure in the State of Michigan" was the clever title of an address presented to the Ingham County Bar Association, Lansing, by Michigan's Assistant Attorney General Charles P. Weber, on November 20 .

* * *

"The Wayne County Medical Society does not sanction the appearance of any of its members before osteopathic or chiropractic societies or groups to discuss medical subjects."—Ruling of The Council of the Wayne County Medical Society, published in Detroit Medical News, December 2, 1946.

(Continued on Page 130)



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(Continued from Page 128)

The Kent County Medical Society has inaugurated a bowling league of forty physicians who bowl weekly, 4:00 to 6:00 p.m., in Grand Rapids. Interest is increasing weekly, as are also many of the averages. This innovation has proved useful in stimulating good fellowship and understanding among the members.

* * *

Preston H. Scott, Ph.D., Head of the Speech Department at Wayne University, is conducting a series of instructional classes for members of the Wayne County Medical Society Speakers Bureau, in the David Whitney House. These weekly meetings are under the direction of E. F. Dittmer, M.D., Chairman of the Speakers Bureau.

* * *

The Wm. M. Donald portrait has been completed by Artist Roy Gamble of Detroit. After having been on exhibition at the Michigan Artists' Show, Detroit Institute of Art, it has now been delivered to the Wayne County Medical Society for permanent hanging in the David Whitney House, Detroit. Dr. Donald is a past president of the Wayne County Medical Society.

* * *

Michigan newspaper editors, in a recent survey, feel that if new taxes prove necessary, they would favor liquor taxes (21 per cent), beer taxes (18 per cent), increased sales taxes (18 per cent), cigarette taxes (16 per cent), graduated income tax (16 per cent), payroll or gross (flat rate) tax (5 per cent) and a state property tax (1 per cent).

* * *

The Washtenaw County Medical Society has issued an important release containing advice to its members re the administration of influenza vaccine. Copies of this excellently prepared special letter may be obtained by writing L. Dell Henry, M.D., Secretary-Treasurer, Washtenaw County Medical Society, 514 Thompson, Ann Arbor.

* * *

The Wayne County Medical Society's Board of Trustees recently approved the recommendation of the Society's Medical Education Committee, as adopted by the WCMS Council, that a secretary be employed at the Society's headquarters to enable the Medical Education Committee to carry on its proposed program for correlation of postgraduate work in Wayne County.

Congratulations, Wayne County Medical Society!

* * *

"Health Examinations"—a manual for the general practitioner, has been prepared by the Medical Society of the County of New York and reprinted and presented to the medical profession of the country, upon request, with the compliments of Mead Johnson & Co. For complimentary copies of this 144-page booklet, filled with very useful information, interestingly told, write Medical Society of the County of New York, 2 E. 103rd St., New York City.

(Continued on Page 132)

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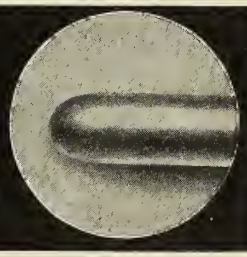

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(Continued from Page 130)

Former Michigan Doctor Named Surgeon General of the Navy.—Captain Clifford A. Swanson of Marquette, Michigan, was appointed by President Truman to succeed Vice Admiral Ross T. McIntire, whose appointment expired November 1. Admiral Swanson is one of the Navy's outstanding surgeons in the ophthalmology-otolaryngology field.

Congratulations, Admiral Swanson!

* * *

Mr. D. R. Coon, well-known manufacturer and fitter of custom orthopedic and prosthetic appliances, announces the change of his firm name from the Otto K. Becker Company to the "D. R. Coon Company." Factory and fitting rooms remain at the same location, 4200 Woodward Avenue, Detroit. Mr. Coon is widely known to the medical profession and has for years been in charge as fitter and manager of the former Otto K. Becker Co.

* * *

National Conference on Medical Service.—The 20th annual meeting of the National Conference on Medical Service will be held at the Palmer House, Chicago, on February 9. The program will include discussions in the fields of national affairs, economics and medical education. All physicians are invited to attend; no registration fee. Cleon A. Nafe, M.D., Indianapolis, is President of the Conference and Creighton Barker, M.D., New Haven, is Secretary.

* * *

Urology Award.—The American Urological Association offers an annual award "not to exceed $500" for an essay (or essays) on the result of some clinical or laboratory research in Urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to residents in urology in recognized hospitals.

For full particulars write the Secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee. Essays must be in his hands before May 1, 1947.

* * *

Colorado State Medical Society officials were hosts to representatives of the Michigan State Medical Society, including Council Chairman E. F. Sladek, M.D., Traverse City, Secretary L. Fernald Foster, M.D., Bay City, Treasurer A. S. Brunk, M.D., Detroit, and H. W. Brenneman, Lansing, MSMS Public Relations Counsel, in Chicago on December 9. The Colorado Society recently increased its dues to $50 per capita, to institute a medical public relations program. The purpose of the December 9 session was a discussion of Michigan's Public Relations Plan.

* * *

Alexander Blain Hospital held its twenty-second annual meeting on November 16 in Detroit. George W. Stark presented an illuminating and interesting talk on "Douglass Houghton—Family Physician," outlining the varied activities and capabilities of one of Detroit's earliest

(Continued on Page 134)

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Two-week Surgical Anatomy & Clinical Surgery starting February 17 and March 17.

One-week Surgery of Colon & Rectum starting March 10 and April 7.

Two-week Surgical Pathology every two weeks.

GYNECOLOGY—Two-week intensive course starting March 17, and April 14.

One-week course in Vaginal Approach to Pelvic Surgery starting March 10 and April 7.

OBSTETRICS—Two-week intensive course starting March 3 and April 28.

MEDICINE—Two-week intensive course starting April 7 and June 2.

One-month course Electrocardiography & Heart Disease starting February 15 and June 16.

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(Continued from Page 132)

physicians who subsequently became its Mayor, and whose geological expeditions resulted in discoveries of valuable copper and other ore deposits in the Upper Peninsula of Michigan where a city is named in his honor. A copy of Mr. Stark's talk is published in the February *Alexander Blain Hospital Bulletin.*

* * *

Directory of Convalescent Homes.—The New York Academy of Medicine is preparing a new edition of the "Directory of Convalescent Homes in the United States." All known convalescent homes will receive a questionnaire early in 1947. Some convalescent homes, not known to the New York Academy of Medicine, may be missed. Physicians having knowledge of recently established convalescent homes are invited to send their names and addresses to E. H. L. Corwin, Executive Secretary, Committee on Public Health Relations, New York Academy of Medicine, 2 East 103rd St., New York 29, N. Y.

* * *

Michigan Society of Anesthetists.—The Michigan Society of Anesthetists held its regular meeting on November 21, 1946, at the Olds Hotel, Lansing. Dr. Ivan B. Taylor, of Detroit, presided. Following the business meeting, a series of case reports were given by various members regarding everyday problems in anesthesia.

The next meeting of the Michigan Society of Anesthetists will be January 16, probably at the Olds Hotel in Lansing. All physicians interested in anesthesia and doing anesthesia are invited to attend. For exact notices of the meetings and dinner reservations, write Dr. Mary Lou Byrd, Secretary, Butterworth Hospital, Grand Rapids, Michigan.

* * *

When asked what they considered Michigan's important current problems, *38 per cent of the editors said solving the state's financial problems was most imperative.* Administrative and organizational troubles (15 per cent), labor legislation (9 per cent), proper provision for the insane and institutional cases (9 per cent) and Michigan educational problems (8 per cent) were other items placed high on the list by the editors.

Taxation committees of the Legislature proposed new taxes on everything from cigarettes to stored natural gas, but feel the problem can best be solved by either a three mill property tax and/or state income tax.

* * *

Physician-Population Ratio.—The Michigan Hospital Survey recently completed and published gives the number of Doctors of Medicine in the state as one to 985 persons. The greatest concentration was in Washtenaw, one doctor to 334 persons. Luce comes second with one to 675, Calhoun one to 683, Grand Traverse 709, Kalamazoo 776, Wayne 828, Kent and Jackson each 870, Clinton 941, Ingham 821, Livingston 993. These are the only counties with a proportion of population to active doctors under 1000. There are eleven counties with a proportion over 2000, and one, Gladwin,

(Continued on Page 136)

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(Continued from Page 134)

3,128. In Oscoda the survey lists one active doctor, but we do not have any recorded there. In three counties they find only two doctors each.

* * *

The Flint Regional Fracture Committee and The Hurley Hospital (Division for Surgery of Trauma) presented a program for the Michigan Regional Fracture Committee of the American College of Surgeons in Hurley Hospital, Flint, on November 20. "The Management of a Fracture Service in an Open Hospital" was presented by George J. Curry, M.D.

"The Basic Principles in Amputation of Extremities" was the subject of Harold L. Woughter, M.D.; "The Management of Thoracic Injuries" was given by Stephen M. Gelenger, M.D.; "The Management of Dislocations of the Hip" by Hardie B. Elliott, M.D. T. Sidney Conover, M.D., spoke on "The Management of the Severely Burned," and Don L. Bishop, M.D., on "The Management of Fractures of the Ulna." The attendance was 182.

* * *

Hugh W. Brenneman, MSMS Public Relations Counsel, addressed the Women's Auxiliary of Bay County Medical Society on November 13 on the subject, "Medical Public Relations and Current Developments in Medical Economics." On November 21, he spoke to the senior class in Government of Sexton High School, Lansing, on the topic "Political Medicine and What It Offers To You." He addressed the Lansing Home Builders Association on December 2 on "Medical Service." He appeared before the Rotary Club of Coldwater, Michigan, on December 31, and the Business and Professional Women's Association in Bay City on February 10, speaking on "Health is Not a Private Affair."

Brenneman also was guest speaker at the Public Relations Conference of the Medical Society of Virginia in Richmond on December 19. He spoke on "Michigan's Public Relations Plan."

* * *

The late James D. Bruce Honored.—The following resolution was adopted by the Board of Trustees of the Michigan Foundation for Medical and Health Education at its October 31, 1946, meeting:

WHEREAS, many of the aims and principles of the Michigan Foundation for Medical and Health Education come from the work and accomplishments in medical education and in postgraduate medical education of Doctor James Deacon Bruce, and

WHEREAS, Doctor Bruce was one of the Founders and Trustees of the Michigan Foundation for Medical and Health Education, and

WHEREAS, the advice and philosophy for education of Doctor Bruce has been used and adopted in the past and in the planning for the future, and

WHEREAS, the death of Doctor Bruce is a tremendous loss to the Michigan Foundation for Medical and Health Education, now therefore

BE IT RESOLVED that we, the Trustees of the Michigan Foundation for Medical and Health Education, extend our profound sympathies to Mrs. Bruce and express our recognition that in the passing of Doctor Bruce, the general advancement of medical education suffers a grievous loss.

Say you saw it in the Journal of the Michigan State Medical Society

Council and Committee Meetings

Public Relations Committee—Lansing, October 13, 1946
Cancer Control Committee—Lansing, October 17, 1946
Mental Hygiene Committee—Detroit, October 17, 1946
Committee on National Health Bill—Ann Arbor, October 26, 1946
Venereal Disease Control Committee—Lansing, October 27, 1946
Committee on High School Athletic Accident Benefit Plan—Lansing, October 30, 1946
Michigan Foundation for Medical and Health Education—Detroit, October 31, 1946
Sub-Committee on Education, Cancer Control Committee—Ann Arbor, November 7, 1946
Preventive Medicine Committee—Detroit, November 13, 1946
Sub-Committee on Ways and Means, Cancer Control Committee—Lansing, November 14, 1946
Committee on Scientific Work—Detroit, November 17, 1946
Executive Committee of The Council—Detroit, November 20, 1946
Sub-Committee on Fact Finding, Cancer Control Committee—Detroit, December 3, 1946
Mental Hygiene Committee—Eloise, December 5, 1946
Sub-Committee of Rheumatic Fever Control Committee—Detroit, December 9, 1946
Committee on Distribution of Medical Care—Detroit, December 11, 1946
Cancer Control Committee—Lansing, December 12, 1946
Special Scientific Radio Committee—Ann Arbor, December 14, 1946
March Conference Committee—Ann Arbor, December 14, 1946
Liaison Committee with Michigan Crippled Children Commission—Detroit, December 19, 1946
Executive Committee of The Council—Lansing, December 22, 1946
The Council—Detroit, January 31-February 1, 1947
Committee on Uniform Fee Schedule for Governmental Agencies—Detroit, February 1, 1947.

* * *

Cancer Day—Genesee County Medical Society—March 19, 1947, is the date of the Second Annual Cancer Day sponsored by the Genesec County Medical Society, to be held in Flint. The scientific program will be held in the auditorium at Hurley Hospital and the following speakers will participate:

1. A. C. Furstenberg, M.D., Dean of University of Michigan Medical School.

2. George Papanicolaou, M.D., Assistant Professor of Anatomy, Cornell Medical School.

3. Gavin Miller, M.D., Professor of Surgery, McGill University, Montreal, Canada.

4. David Steel, M.D., Chief Radiologist, St. Joseph's Hospital, Cleveland.

5. Cornelius P. Rhoads, M.D., Medical Director of Memorial Hospital, New York City.

The evening program will be held in the ballroom of the Durant Hotel and is open to the laity. The speaker will be C. F. Kettering, Detroit. At the morning session, Norman F. Miller, M.D., Professor of Obstetrics and Gynecology, University of Michigan Medical School, and Chairman of the Cancer Committee of the Michigan State Medical Society, will preside. At the afternoon

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session, William A. Hyland, M.D., President of the Michigan State Medical Society, will preside.

* * *

The Pere Marquette Streamliner will transport many doctors of medicine and their wives to the 82nd Annual Session of the Michigan State Medical Society, to be held at the Pantlind Hotel-Civic Auditorium, Grand Rapids, September 23, 24, 25, and 26, 1947. A certified registration of over 2,000 doctors of medicine, from all parts of Michigan, is anticipated at the 1947 Grand Rapids session. The Program Committee is arranging a stellar program, with presentations from Tuesday noon to Friday noon.

* * *

Martha Longstreet, M.D., was honored by the Saginaw County Medical Society at a testimonial dinner held at the Hotel Bancroft, Saginaw, on December 10. Alexander R. McKinley, M.D., acted as toastmaster, and the appreciation of Dr. Longstreet and her long medical career was given by Rockwell M. Kempton, M.D., while "Dr. Longstreet's Contribution to the Community" was treated by Mr. R. Perry Shorts.

Dr. Longstreet was toasted as "Beloved, revered, admired by all who know her; whose name connotes Physician in the truest sense of the word."

* * *

The American Physiotherapy Association recommends "That in cases in which physical medicine is indicated (in Veterans Administration cases), the medical services shall be rendered only by a physician possessing a license to practice medicine and surgery without restriction in the state. The licensed physician in charge of a case, however, may delegate the performance of care not requiring the exercise of professional judgment and discretion to a person who is either (1) a member of the American Physiotherapy Association, (2) a registrant of the American Registry of Physical Therapy Technicians, or (3) a graduate of a school of physical therapy approved by the Council on Medical Education and Hospitals of the American Medical Association, provided that the care is rendered only on the prescription of and under the direction of the physician in charge of the case."

A list of approved schools of physical therapy may be obtained by writing Frank H. Krusen, M.D., and John S. Coulter, M.D., 1790 Broadway, New York 19, N. Y.

* * *

Michigan surgeons who were received into Fellowship in the American College of Surgeons at the December, 1946, convocation in Cleveland, included: George D. Albers, M.D., East Grand Rapids, Morris E. Bachman, M.D., Detroit, August F. Bliesmer, M.D., St. Joseph, Glen A. Brough, M.D., Detroit, Francis R. Byron, M.D., Ann Arbor, John E. Clifford, M.D., Detroit, Claude C. Cody, M.D., Ann Arbor, Norman W. Frink, M.D., Detroit, William J. Fuller, M.D., Ann Arbor, J. Gregory Grego, M.D., Detroit, Leonard P. Heath, M.D., Detroit, John G. Hemming, Jr., M.D., Detroit, Melbourne J. King, M.D., Detroit, Carl F. List, M.D., Ann Arbor, Lyndle R. Martin, M.D., Detroit, Chester B. McVay,

(Continued on Page 142)

Say you saw it in the Journal of the Michigan State Medical Society

THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

THE PRINCIPLES OF NEUROLOGICAL SURGERY. By Loyal Davis, M.S., M.D., F.A.C.S., Ph.D., D.Sc.(Hon.), Professor of Surgery and Chairman of the Division of Surgery, Northwestern University Medical School, Chicago. Third Edition, Thoroughly Revised. 192 Engravings, 348 Illustrations and 5 plates, 4 colors. Philadelphia: Lea & Febiger, 1946. Price, $7.50.

This book makes no attempt to be an exhaustive treatise on the subject of neurosurgery, but does attempt to show the profession what can be done, thus assuring our patients much better advice. The doctors and students who have read this book will have a firmer groundwork on neurosurgery and its possibilities. Tests for the various motions of the body are described and illustrated as a fundamental to diagnosis. Tests of sensation are illustrated; also the distribution of nerves. The functions of the cranial nerves, and tests for their normal activities. A considerable portion of the book is devoted to intracranial tumors. Spinal cord injuries, intracranial abscesses and peripheral nerve injuries are all well described, and with much detail. A most useful book for any practitioner.

* * *

PRINCIPLES OF HEMATOLOGY. With 106 Illustrative Cases. By Russell L. Haden, M.A., M.D., Chief of the Medical Division of the Cleveland Clinic, Formerly Professor of Experimental Medicine in the University of Kansas School of Medicine. Third Edition, Thoroughly Revised. 171 Illustrations, 173 Original Photomicrographs and 95 Original Charts and Drawings. Philadelphia: Lea & Febiger, 1946. Price, $5.00.

This book is primarily a simplification of the study of the blood diseases. The forms and development of the parts of the blood are given, then the laboratory techniques, and a classification of all the blood diseases. These are all illustrated with scores of plates showing the forms of cells present, and the size and volume. The last half of the book gives 106 well-detailed case reports illustrating the diseases of the blood previously sketched. It is a most useful volume.

* * *

EARLY AMBULATION AND RELATED PROCEDURES IN SURGICAL MANAGEMENT. By Daniel J. Leithauser, M.D., F.A.C.S., Chief Surgeon, St. Joseph Mercy Hospital, Detroit, Michigan. Springfield, Illinois: Charles C. Thomas, 1946. Price, $4.50.

Early ambulation has become a well-established method with postoperative patients in recent years. Dr. Leithauser stumbled more or less upon it when an unruly patient insisted on getting up and leaving the hospital the next day after appendectomy, and had no bad results. Many another surgeon has had the same experience, but it did not lead to much investigation, much

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experimentation and the writing of a book. This book, over 200 pages, is most interesting, and very instructive. The author investigated surgical methods and suture materials that would permit early walking about. We can heartily recommend this book to our surgeons and students. It offers hopefuless of improved results, but also warnings of unwise procedures.

* * *

THE CHEST. A Handbook of Roentgen Diagnosis. By Leo G. Rigler, M.D., Professor and Chief, Department of Radiology, University of Minnesota. Chicago: The Yearbook Publishers, Inc., 1946. Price, $6.50.

After short introductory statements and descriptions this book has hundreds of chest pictures, two or three of a case oftentimes. On the opposite page is a description of the case and the diagnosis, with outlines of the significant finds leading to the diagnosis. The book is very complete, the cases almost all having been taken from the author's own files, and most of them having been confirmed as to diagnosis.

* * *

HYGIENE, A Textbook for College Students on Physical and Mental Health from Personal and Public Aspects. By Florence L. Meredith, B.Sc., M.D., Fellow of the American Medical Association, American Public Health, and American Psychiatric Associations; Professor of Hygiene and Public Health, Tufts College. Fourth edition. Philadelphia: The Blakiston Company, p. 946. Price $4.00.

This college grade textbook is most interestingly written, readable, and full of the most intriguing information. The questions of personal and sometimes public health run throughout the book, but there are interspersed chapters on historical development, on the great leaders in medicine from Imenhotep and Esculapius, Hippocrates, Aristotle, Celsus, Galen, to the more modern Harvey, Sydenham, Morgagni, Virchow, and Pasteur. Their place in development is told. Medical science of today is contrasted with olden times. Public health work, infectious diseases, immunity, the costs and distribution of costs and adequate care are mentioned. This is sufficient to stimulate the interest of the student. The theories and principles of hygiene and disease prevention are given in interest-provoking form.

There is a section on mental hygiene, and one on the principles of heredity. This book is easy reading, and stimulating.

* * *

PSYCHOTHERAPY IN GENERAL MEDICINE, Report of an Experimental Postgraduate Course: By Geddes Smith, Associate, The Commonwealth Fund. New York: The Commonwealth Fund, 1946.

This is the report, abstract and outline of a course beginning Monday, April 1, and extending through Saturday, April 13, both morning and afternoon sessions,

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with several evening sessions. This is an interesting outline which would be useful for others planning such courses.

* * *

X-RAYS AND RADIUM IN THE TREATMENT OF DISEASES OF THE SKIN. By George M. MacKee, M.D., Professor of Clinical Dermatology and Director of the Department of Dermatology, New York Postgraduate Medical School and Hospital; and Anthony C. Cipollaro, M.D., Assistant Professor of Dermatology and Assistant Director of the Department of Dermatology (Skin and Cancer Units) New York Postgraduate Medical School and Hospital. Contributor: Hamilton Montgomery, M.D., Associate Professor of Dermatology, Mayo Foundation, Graduate School, University of Minnesota. Fourth edition, thoroughly revised. 321 engravings and 4 colored plates. Philadelphia: Lea & Febiger, 1946. Price $10.00.

The book gives the nature and use of x-ray and radium and other radiations, with the therapeutic usage, methods of application, of measurement, dosage for general use, and effect on tissues. The second part of the book takes up individual diseases and gives full discussions and treatments. There is a section on treatment of malignant disease and a full discussion of the medicolegal aspects of this treatment. This book is wonderfully illustrated, and well planned. It should be on the shelves of every dermatologist and every radiologist giving treatments.

* * *

OUTLINE OF CYSTOSCOPIC TECHNIC AND DIAGNOSIS. By Geza Schinagel, Instructor in Urology, Wayne University College of Medicine, Ann Arbor: Edwards Bros., Inc., 1946.

In a mimeographed outline, the author gives the essential features of urethroscopic and cystoscopic procedure. Types of instruments are described; indications and contraindications for instrumentation mentioned, as well as various functional tests. Numerous black and white diagnostic drawings assist the reader in understanding the text. This is a helpful outline for the student.

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(Continued from Page 138)

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"Penicillin Paragraphs" is the first of a series of concise, ready-reference booklets, mailed to all active doctors of medicine by Schenley Laboratories. A new edition will be issued monthly, according to Charles E. Dutchess, M.D., Medical Director.

* * *

X-rays of the chest are a mandatory adjunct of medical examinations under the Michigan State Board of Cosmetology, following a new ruling. These examinations of the chest are a part of the medical examination and must be performed at the time the general examinations are performed by the doctor of medicine.

* * *

Your federal narcotic license must be renewed as of July 1, 1947. Send your application plus fee to Bureau of Narcotics, Federal Bldg., Detroit.

* * *

The Upjohn Company of Kalamazoo has opened its twelfth branch, in Los Angeles, to serve southern California plus parts of Arizona and Nevada.

Frank E. Smith has been appointed Director of Associated Medical Care Plans, with offices at 535 N. Dearborn Street, Chicago 10 (American Medical Association), as of December 1, 1946.

* * *

"Why the Private Practice of Medicine Furnishes this Country with the Finest Medical Care" is the subject of an essay contest for junior and senior high school students, launched in January by the Association of American Physicians and Surgeons, which is offering $1,000 first prize, $500 second prize and $100 third prize for the three best essays in the nation.

The contest ends April 30, 1947, and the winners will be announced May 15, 1947, according to Joseph C. Bunten, M.D., Chairman of the Committee on Annual Essay Contest.

* * *

Medical Economic Courses at University of Michigan—Members of the senior class of the University of Michigan Medical School heard three lectures on medical economics in November. R. S. Morrish, M.D., Flint, spoke on "Medical Organization," November 19; J. E. Livesay, M.D., Flint, spoke on "Business of Medicine," November 22; and Wilfrid Haughey, M.D., Battle Creek, spoke on "Plans for Medical Distribution," November 26.

The juniors heard the Morrish and Haughey lectures on November 23 and December 14, as well as a dissertation on "The Business of Medicine" by J. S. DeTar, M.D., Milan, on November 30, and on "Rural Medicine" by John Rodger, M.D., Bellaire, on December 7.

* * *

The Washtenaw County Medical Society adopted a testimonial resolution to the memory of the late James D. Bruce, M.D., at its December meeting. One of the paragraphs reads, "Those of us who were privileged to know Doctor Bruce well, will always be thankful for his kind but keen insight and advice concerning medical problems, his gift to inspire younger physicians, and his ability to foresee and complete plans for the solution of medical and public health problems."

* * *

About 65,000 veterans are applying monthly for admission to Veterans Administration hospitals or homes.

Construction is under way on new Veterans Administration hospitals or for additions to existing hospitals, totalling nearly $37,000,000 in contract awards.

* * *

Report on Veterans Administration—Michigan Medical Service experience since the Michigan program began March 1, 1946:

60,000 cases processed.

4,200 Michigan doctors of medicine participating.

8,000 cases per month being handled at the present time, two-thirds treatment cases, and one-third examination.

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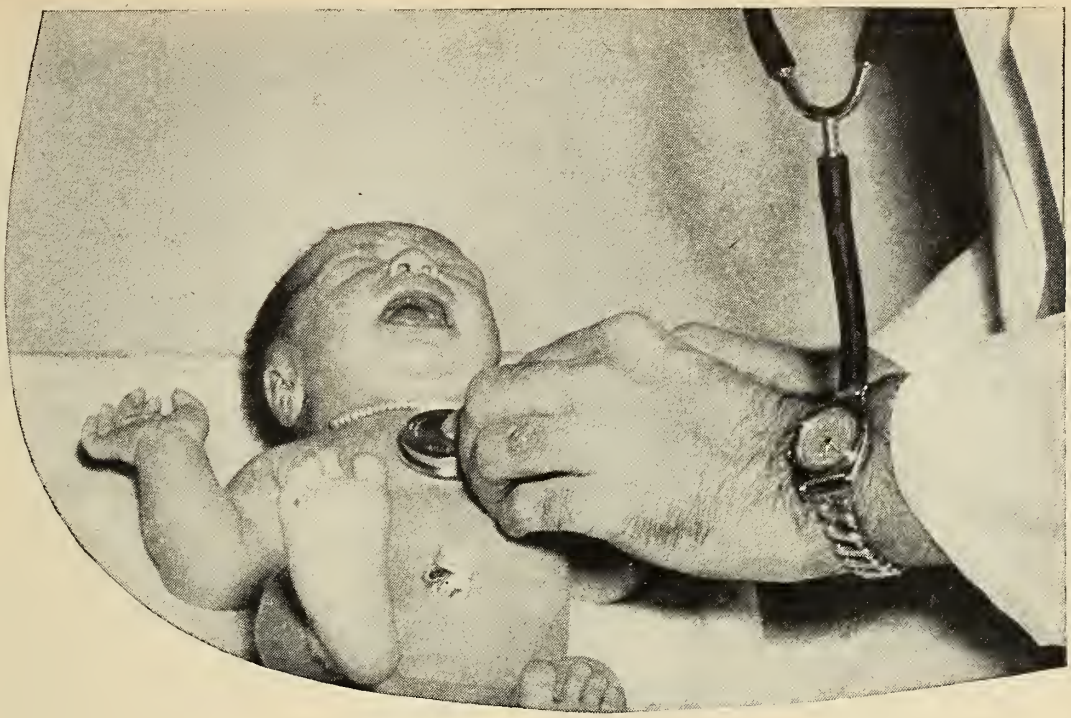

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What the Hospital Survey and Construction Act Means to the Hospitals of Michigan

By Ralph M. Hueston
Superintendent, Hurley Hospital
Flint, Michigan

THE ORIGINAL HOSPITAL survey committee appointed by the Board of Trustees of the Michigan Hospital Association evolved into the Michigan Hospital Survey Committee appointed by the State governor. The membership of this committee included representatives of hospitals, the medical profession, the nursing profession, the general public, and several special groups. The committee held its first meeting December 15, 1944. At this meeting an Executive Committee was elected. The Executive Committee was instructed to prepare a survey report. The survey on which the report was based was conducted by the Study Committee of the National Committee on Hospital Care. Dr. A. C. Bachmeyer was director of the Study Committee.

The survey report was submitted to and approved by the Michigan Hospital Survey Committee at a meeting held September 5, 1946. The data and recommendations contained in this report covered approximately 250 pages. A condensed report covering only thirteen pages has been prepared for the convenience of those who are not especially interested in the exhaustive detail contained in the complete report. A copy of the complete report may be obtained upon request.

Never has there been a time when there was so much demand for hospital service as there is at the present time, and never was there a time when there was so much planning for expanding hospital facilities and services as there is at the present time. As a result of these two conditions, there never was a time when there was a greater need for the providers of hospital service to co-ordinate their efforts in order to assure the consumers of hospital service a maximum of benefits.

The hospitals of Michigan have taken three important steps forward during recent years, which will help them meet today's challenge. In 1939 they joined with the hospitals in Indiana, Illinois, and Wisconsin, as members of the Tri-State Hospital Assembly. In 1940 they appointed a hospital survey committee to study the hospital facilities available in Michigan. In 1946 they reorganized the Michigan Hospital Association as a full-time endeavor. The results of these three actions have provided the hospitals in Michigan with more opportunities for improving their present services and for planning their future services than are available to hospitals any place else in the United States.

From the survey report, hospitals know what facilities and services are now available and what should be included in plans for changing or expanding these facilities and services. Any program for changing or expanding facilities includes the problems of financing. For most hospitals, financing capital improvements presents a major problem. Fortunately the Federal Government has recognized that hospitals need aid in helping to finance such programs. This was part of the reason for introducing Senate Bill 191, which has become Public Act No. 725 under the title, "Hospital Survey and Construction Act." This act is divided into three sections: (1) Surveys and Planning, (2) Construction of Hospitals and Related Facilities, and (3) Policy Governing the Administration of the Act.

The section on "Surveys and Planning" provides an authorization of three million dollars to be used for making payments to states for surveys. While it is true that the general survey for Michigan has been completed, there is still a great deal of survey work and planning to be done. For instance, it is necessary to do some more work in the Detroit area. Also, it is necessary to develop more detailed plans so far as nervous and mental hospitals, tuberculosis sanitaria and chronic disease hospitals are concerned.

The section on "Construction of Hospitals and Related Facilities" is of most importance to Michigan Hospitals. The major provisions of this section may be divided under three general headings:

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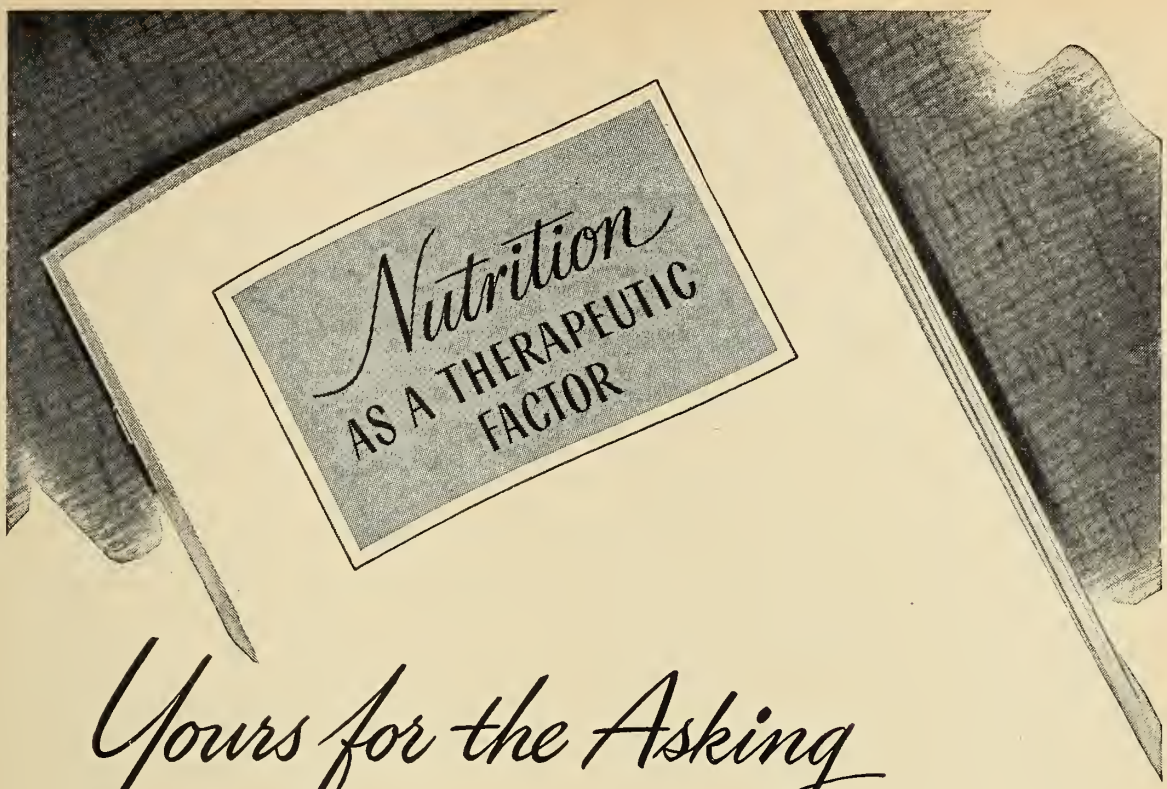
Presented at Conference arranged by Michigan Hospital Association, January 17, 1947, at Detroit.



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(Continued from Page 158)

(1) appropriations, (2) general regulation, and (3) state plans.

The Act provides authorization in the amount of seventy-five million dollars a year for five years, beginning with the fiscal year July, 1946, to July, 1947. Unfortunately, the Act was passed after the budget for this fiscal year was approved, with the result that no funds are provided in the budget to pay the authorization intended for this year. To compensate for such a condition and also to provide further for the maximum use of the appropriation, the Act provides that any portion of the appropriation unused in one fiscal year may be used during the succeeding fiscal year. If Congress appropriates the full amount authorized by the law, there will be 150 million dollars available for the fiscal year July, 1947, to July, 1948. The money appropriated is to be used for making payments to states and political subdivisions thereof, and public or other nonprofit agencies in the state which have submitted construction plans approved by the Surgeon General. The plan for allocating Michigan's share of the appropriation has not been determined. However, after the Federal Hospital Council had approved the rules and regulations on November 15, Dr. Wilson and Mr. Davis attempted to set up priorities for Michigan on a basis of what they knew about the situation. There are three areas in Michigan where there are no hospital facilities. These areas undoubtedly will be given highest priority, because of Section 622-D of the Act which specifies that special consideration to hospitals serving rural communities and areas with relatively small resources is required. There are fourteen other comparatively rural areas where the present hospitals are old houses or similarly inadequate structures. No doubt these will come next, so far as priorities are concerned. Then there are quite a number of hospitals classified as community hospital centers where the plants need modernization and enlargement. These probably will be next in line for consideration.

The maximum subsidy available for any single project is 33⅓ per cent of its cost. Michigan's share of the appropriation will be that portion which is equal to the per capita income of Michigan in relation to the per capita income of the United States. Reduced to dollars, this means that Michigan's share will be approximately two million dollars a year or a total of approximately ten million dollars for the five-year program. If the total cost of the approved projects in this period does not exceed thirty million dollars, each approved project will receive a subsidy equal to 33⅓ per cent of its cost.

The "General Regulation" provides that, within six months after the enactment of the Hospital Survey and Construction Act, the Surgeon General, with the approval of the Federal Hospital Council and the administrators, is to prescribe:

1. The number of general hospital beds required to provide adequate hospital services to people residing in a state, and the general distribution of such beds. The total number of beds for any state is not to exceed four and one-half per 1,000 population except that in states having less than twelve and more than six persons per square mile the limit is to be five beds per 1,000. In states having six persons or less per square mile the limit will be five and one-half beds per 1,000.

2. The number of beds required to provide adequate hospital services for tuberculous, mental, and chronic-disease patients in a state and the general method of distribution. The number of beds for tuberculous patients is not to exceed two and one-half times the average annual deaths from tuberculosis over the period from 1940 to 1944. The total number of beds for mental patients is not to exceed five per 1,000 population, and for chronic-disease patients is not to exceed two per 1,000.

3. The number of public health centers is not to exceed one per 30,000 population, except that in states having less than twelve persons per square mile, it is not to exceed one per 20,000.

4. The general standards of construction and equipment for hospitals of different classes and in different types of locations.

Any state wishing to avail itself of Federal funds under the Hospital Survey and Construction Act must comply with the following:

1. Designate a single state agency which will have authority to carry out building plans.

2. Designate a state advisory council which is to include representatives of non-government organizations or groups, and of state agencies concerned with the operation, construction, or utilization of hospitals, and representatives of consumers of hospital services.

3. Set forth a hospital construction program meeting this law and rules and regulation of the Surgeon General and the Federal Hospital Council.

4. Provide for methods of administration of the state plans including methods relating to the establishment of personnel standards on a merit basis.

5. Provide minimum standards, to be fixed in the discretion of the state, for the maintenance and opera-

(Continued on Page 162)

IT IS
GOOD PRACTICE

. . . in judging the irritant properties of cigarette smoke . . . to base your evaluation on scientific research. In judging *research,* you *must* consider its *source**.

PHILIP MORRIS claims of superiority are based *not* on anonymous studies, but on research conducted only by competent and reliable authorities, research reported in leading journals in the medical field.

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*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

(Continued from Page 160)

tion of hospitals which receive Federal aid under this law.

6. Provide for opportunity for hearings.

7. Provide for reports to the Surgeon General as he may require.

If the Surgeon General disapproves any state plan, the state agency may apply to the Federal Hospital Council for a hearing.

If any state has not enacted legislation prior to July 1, 1948, providing that compliance with minimum standards of maintenance and operation shall be required in the case of hospitals which are to receive Federal aid under this law, such states will not be entitled to further allotments.

Up to the present time, Michigan has not enacted legislation to meet this provision of the Hospital Survey and Construction Act. Therefore, it is imperative that the necessary legislation is enacted at this session of the legislature if the hospitals and residents of Michigan are to benefit under the Hospital Survey and Construction Act. Each of you is urged to use your influence to help get such legislation enacted.

The "Administration of the Act" has been delegated to the Surgeon General and the Federal Hospital Council under the following program:

1. The Surgeon General is authorized to make the administrative regulations and perform the functions he finds necessary to carry out the provisions of this law.

2. These regulations are to be approved by the Administrator of the Federal Security Agency.

3. The Surgeon General must consult with a Federal Hospital Council consisting of the Surgeon General, chairman ex officio, and eight members appointed by the Administrator. Four of the eight members must be persons outstanding in the fields of hospital and health activities, three of whom must be authorities in the operation of hospitals. The other four members must be persons familiar with the need for hospital services in urban or rural areas. Each member holds office for four years. The Council may appoint advisory and technical committees deemed necessary to carry out its functions.

Our most important responsibility right now is to see that the necessary legislation is passed to qualify the hospitals in Michigan for benefits under the Hospital Survey and Construction Act. Four million dollars in subsidies is at stake for this next fiscal year, and six million more during the succeeding three years. We who are the providers of hospital service owe it to those who are the consumers of this service to do whatever is within reason to meet today's demand for hospital service. Ten million dollars in subsidies is available to Michigan to finance the building and equipping of additional facilities to help meet today's demand for hospital service.

CARE OF THE HEART

The following release is endorsed by the Rheumatic Fever Control Committee:

During the past third of a century, the improvement in mortality from heart disease was most pronounced in the younger age groups and decreased progressively with advance in age. The death rate from diseases of the heart and arteries, corrected for the aging of the population, dropped virtually 30 per cent between 1911-15 and 1940-44, according to experience among the Industrial policyholders of the Metropolitan Life Insurance Company. This reduction in mortality from the principal cardiovascular-renal diseases has been particularly marked among white females—37 per cent in the above-mentioned period. Among the males, the decrease in mortality, while not as marked as among the females, was 25 per cent, still a quite substantial reduction. This still leaves much to be desired in the field of early diagnosis and immediate initiation of adequate cardiac regimes in order to reduce to a minimum incapacity and mortality from these conditions. Concentration of effort must now be placed on teaching the public what is known about prevention, early recognition, and care of cardiac lesions.

In order to assist in the attainment of this goal, the Metropolitan Life Insurance Company is conducting a special campaign on heart disease during the fall and winter months. At that time, the Company's more than 20,000 Field Representatives, in co-operation with official and voluntary agencies, will reach the homes of millions of policyholders with a recently published pamphlet, *Your Heart,* developed in co-operation with the American Heart Association. A lay educational film on heart disease is also being prepared. Distribution will be made to physicians of a packet in which will be included material of special interest to doctors, and a scientific exhibit on heart disease, first shown at the AMA meeting in San Francisco, is available for State and local professional meetings.

The public is becoming more acutely aware of cardiac hygiene than ever before—a growing interest that should be cultivated and guided with judgment as well as vigor.

FULBRIGHT-TAFT BILL

The Fulbright-Taft Bill (S-140) is up for hearings before the Senate Committee on Labor and Public Welfare. This bill is vicious because it will place health service subordinate to a layman cabinet member probably representing social service. Letters of protest to senators and your representative will help.

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Michigan Postgraduate Clinical Conference

First Annual Session

Book-Cadillac Hotel, Detroit, Wednesday-Thursday-Friday, March 12-13-14, 1947.

This conference will be presented under the sponsorship of the Michigan State Medical Society in co-operation with the Wayne County Medical Society, the University of Michigan Medical School, Wayne University College of Medicine, University of Michigan Department of Postgraduate Medicine, and the Michigan Foundation for Medical and Health Education.

WEDNESDAY, MARCH 12, 1947

8:30 AM *Registration—Exhibits Open*—Italian Garden, Fourth Floor, Book-Cadillac Hotel

First Assembly
Grand Ballroom

L. Fernald Foster, M.D., Bay City, *Chairman*

8:55 AM Welcome.....William A. Hyland, M.D., Grand Rapids, President MSMS
W. B. Harm, M.D., Detroit, President, Wayne County Medical Society
9:00- 9:20 "Gynecological and Obstetrical Problems in Industrial Medicine and Surgery" .....Max Burnell, M.D., Flint
9:20- 9:40 "Varicose Veins".....E. A. Osius, M.D., Detroit
9:40-10:00 "Fluid Balance in Children".....P. V. Woolley, M.D., Detroit
10:00-11:00 Intermission to View Exhibits
11:00-11:20 "The Evaluation of the Lowered Metabolic Rate"..R. M. McKean, M.D., Detroit
11:20-11:40 "Treatment of Common Fractures".....H. H. Stryker, M.D., Kalamazoo
11:40-12:00 "Anti-Histamine Compounds".....S. W. Insley, M.D., Detroit

12:15- 1:15 PM LUNCHEON, English Room
E. D. Spalding, M.D., Detroit, *Chairman*
1:15- 1:45 "Newer Methods in the Treatment of Anemias"..C. C. Sturgis, M.D., Ann Arbor

Second Assembly
Grand Ballroom

E. I. Carr, M.D., Lansing, *Chairman*

2:00- 2:20 PM "Tumors of the Breast".....R. D. McClure, M.D., Detroit
2:20- 2:40 "Atypical Pneumonia".....B. M. Bullington, M.D., Saginaw
2:40- 3:00 "The Nasopharynx in a Streptococcus Epidemic"
O. B. McGillicuddy, M.D., Lansing
3:00- 4:00 Intermission to View Exhibits
4:00- 4:20 "Evaluation of the Serological Tests for Syphilis"..A. C. Curtis, M.D., Ann Arbor
4:20- 5:00 CLINICAL-PATHOLOGICAL CONFERENCE—A Medical Diagnostic Problem. Conducted by Plinn F. Morse, M.D., Detroit.

Third Assembly
Grand Ballroom

Grover C. Penberthy, M.D., Detroit, *Chairman*

8:00 PM Symposium on "Protection Against Infectious Disease"
J. A. Johnston, M.D., Detroit
Thomas Francis, Jr., M.D., Ann Arbor
Hardy A. Kemp, M.D., Detroit
10:00 SMOKER. Entertainment sponsored by Wayne County Medical Society.

THURSDAY, MARCH 13, 1947

8:30 AM *Registration—Exhibits Open*—Italian Garden, Fourth Floor, Book-Cadillac Hotel

Fourth Assembly
Grand Ballroom

H. R. Prentice, M.D., Kalamazoo, *Chairman*

9:00- 9:20 AM "The Minimal Tuberculosis Infection".....J. W. Towey, M.D., Powers
9:20- 9:40 "Treatment of Burns".....C. N. Weller, M.D., Detroit
9:40-10:00 "Sterility in the Female".....N. F. Miller, M.D., Ann Arbor

10:00-11:00 Intermission to View Exhibits
11:00-11:20 "Choice of Anesthesia in General Practice".....Joe DePree, M.D., Grand Rapids
11:20-11:40 "Intestinal Obstruction".....C. G. Johnston, M.D., Detroit
11:40-12:00 "The Clinical Diagnosis of Cardiac Arrhythmias"
C. B. Beeman, M.D., Grand Rapids
12:15- 1:15 PM LUNCHEON, English Room
B. B. Bushong, M.D., Traverse City, *Chairman*
1:15- 1:45 "Pain of Spinal Origin".....C. E. Badgley, M.D., Ann Arbor

Fifth Assembly

Grand Ballroom

Frank A. Weiser, M.D., Detroit, *Chairman*

2:00- 2:20 PM "The Application of Psychiatry to Medical Practice"
J. M. Dorsey, M.D., Detroit
2:20- 2:40 "Respiratory Infections in Infants".....M. Cooperstock, M.D., Marquette
2:40- 3:00 "Abdominal Surgery in Infancy and Childhood"....C. D. Benson, M.D., Detroit
3:00- 4:00 Intermission to View Exhibits
4:00- 4:20 "Ocular Emergencies in General Practice".....F. B. Fralick, M.D., Ann Arbor
4:20- 5:00 CLINICAL-PATHOLOGICAL CONFERENCE—A Surgical Case.
Conducted by C. V. Weller, M.D., Ann Arbor

Sixth Assembly

Grand Ballroom

8:00-10:00 PM Panel Discussion on "Pre- and Post-Operative Care of the Surgical Patient."
F. A. Coller, M.D., Ann Arbor, *Moderator*
L. C. Carpenter, M.D., Grand Rapids
R. L. Mustard, M.D., Battle Creek
D. J. Leithauser, M.D., Detroit

FRIDAY, MARCH 14, 1947

8:30 AM *Registration—Exhibits Open*—Italian Garden, Fourth Floor, Book-Cadillac Hotel

Seventh Assembly

Grand Ballroom

S. W. Hartwell, M.D., Muskegon, *Chairman*

9:00- 9:20 AM "Physical Medicine".....Col. A. E. White, M.C., Battle Creek
9:20- 9:40 "Surgical Management of Cranio-Cerebral Trauma"
E. S. Gurdjian, M.D., Detroit
9:40-10:00 "The Use of X-Ray in Obstetrics.....E. Walter Hall, M.D., Detroit
10:00-11:00 Intermission to View Exhibits
11:00-11:20 "Neonatal Care".....J. L. Wilson, M.D., Ann Arbor
11:20-11:40 "Management of Urinary Tract Infections".....R. M. Nesbit, M.D., Ann Arbor
11:40-12:00 "Rheumatic Fever".....H. H. Riecker, M.D., Ann Arbor
12:15- 1:15 PM LUNCHEON, English Room
A. C. Furstenberg, M.D., Ann Arbor, *Chairman*
1:15- 1:45 "The Intelligent Use of Antibiotics".....G. B. Myers, M.D., Detroit

Eighth Assembly

Grand Ballroom

A. H. Kretchmar, M.D., Flint, *Chairman*

2:00- 2:40 PM CLINICAL-PATHOLOGICAL CONFERENCE—Subject: Gynecology
Conducted by Donald C. Beaver, M.D., Detroit
2:40- 3:00 "Common Skin Diseases".....E. A. Hand, M.D., Saginaw
3:00- 4:00 Final Intermission to View Exhibits
4:00- 4:20 "Peritoneoscopic Studies in Epidemic Jaundice".....T. A. Horan, M.D., Detroit
4:20- 4:40 "Cancer of the Uterus".....A. E. Catherwood, M.D., Detroit
4:40- 5:00 "Early Recognition of Carcinoma of Colon and Rectum"
L. J. Hirschman, M.D., Detroit

End of Conference

Contributions and Pledges to Michigan Foundation for Medical and Health Education

From September 18, 1945 to February 1, 1947

Allegan County Medical Society	$ 85.
Anonymous (Memory of Mother)	$ 1,000.
Regis F. Asselin, M.D., Detroit	5.
R. H. Baribeau, M.D., Battle Creek	50.
Barry County Medical Society	50.
M. G. Becker, M.D., Edmore	1,000.
A. P. Biddle Estate	2,933.81
Branch County Medical Society	85.
C. D. Brooks, M.D., Detroit	1,000.
J. D. Bruce, M.D., Ann Arbor	1,000.
A. S. Brunk, M.D., Detroit	1,000.
E. I. Carr, M.D., Lansing	1,000.
H. R. Carstens, M.D., Philadelphia, Pa	1,000.
L. G. Christian, M.D., Lansing	100.
R. E. Clark, M.D., Detroit	25.
Clinton County Medical Society	50.
C. V. Costello, M.D., Holland	1,000.
H. H. Cummings, M.D., Ann Arbor	1,000.
A. C. Curtis, M.D., Ann Arbor	15.
J. S. DeTar, M.D	1,000.
Dickinson-Iron County Medical Society	80.
Eaton County Medical Society	70.
A. C. Furstenberg, M.D., Ann Arbor	1,000.
L. J. Gariepy, M.D., Detroit	1,000.
Genesee County Medical Society	1,000.
Robt. W. Gillman, M.D., Detroit	1,000.
Gratiot-Isabella-Clare County Medical Society	125.
Grand Traverse-Leelanau-Benzie County Medical Society	167.50
T. J. Heldt, M.D., Detroit	25.
Lee Hileman, M.D., Ecorse	10.
Hillsdale County Medical Society	95.
L. J. Hirschman, M.D., Detroit	1,000.
L. E. Holly, M.D., Muskegon	1,000.
Houghton-Baraga-Keweenaw County Medical Society	140.
R. J. Hubbell, M.D., Kalamazoo	1,000.
Huron County Medical Society	55.
Wm. A. Hyland, M.D., Grand Rapids	1,000.
Ingham County Medical Society	1,572.50
S. W. Insley, M.D., Detroit	1,000.
Jackson County Medical Society	350.
Joint Committee on Health Education	1,000.
Francis Jones, M.D., Lansing	1,000.
F. H. Lashmet, M.D., Petoskey	100.
Lenawee County Medical Society	125.
S. R. Light, M.D., Kalamazoo	100.
Macomb County Medical Society	130.
Manistee County Medical Society	100.
Marquette-Alger County Medical Society	135.
F. F. McMillan, M.D., Charlevoix	100.
Mason County Medical Society	35.
Mecosta-Osceola-Lake County Medical Society	45.
H. A. Meinke, M.D., Hazel Park	50.
Menominee County Medical Society	55.
Michigan Medical Service	10,000.
Mrs. K. B. Miner, Flint	1,000.
Monroe County Medical Society	145.
H. R. Moore, M.D., Newaygo	1,000.
H. L. Morris, M.D., Detroit	1,000.
Muskegon County Medical Society	310.
R. L. Mustard, M.D., Battle Creek	1,000.
Cora Boyce Neal, Grand Rapids	1,000.
Ontonagon County Medical Society	15.
Wm. H. Parks, M.D., Petoskey	100.
A. W. Petersohn, M.D., Battle Creek	25.
L. B. Rasmussen, M.D., Vicksburg	25.
Lawrence Reynolds, M.D., Detroit	1,000.
J. M. Robb, M. D., Detroit	1,000.
J. M. Robb, M.D., Detroit (Memorial to the late J. D. Bruce, M.D.)	100.
John Rodger, M.D., Bellaire	100.
G. B. Saltonstall, M.D., Charlevoix	1,000.
Sanilac County Medical Society	50.
C. A. Scheurer, M.D., Pigeon	20.
E. F. Sladek, M.D., Traverse City	5,000.
Ferris N. Smith, M.D., Grand Rapids	1,000.
St. Clair County Medical Society	220.
Shiawassee County Medical Society	1,000.
H. B. Steinbach, M.D., Detroit	100.
R. H. Stevens, M.D., Detroit	1,000.
C. L. Straith, M.D., Detroit	1,000.
R. H. Strange, M.D., Mt. Pleasant	1,000.
Jerrian VanDellen, M.D., East Jordan	100.
Ralph Wadley, M.D., Lansing	1,000.
R. V. Walker, M.D., Detroit	1,000.
Washtenaw County Medical Society	200.
H. L. Weitz, M.D., Traverse City	100.
C. G. Wencke, M.D., Battle Creek	10.
E. L. Whitney, M.D., Detroit	25.
S. B. Winslow, M.D., Battle Creek	50.
E. R. Witwer, M.D., Detroit	1,000.
Margaret H. Zalen, M.D., Kalamazoo	5.

(Pledge Card on Page 172)

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SUPPLIED as ¼% and 1% in isotonic saline and ¼% in Ringer's with aromatics, bottles of 1 fl. oz.; ½% jelly in convenient applicator tubes, ⅝ oz.

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Michigan Hospital Service

Veterans Program

Michigan Hospital Service has been authorized by the Veterans Administration to contact all accredited hospitals and sanatoriums in Michigan and endeavor to obtain from them an agreement to provide authorized hospital care to the eligible veteran. This activity on the part of Michigan Hospital Service was not confined to those institutions participating in the Michigan Blue Cross Plan, but was extended to include all hospitals in this state carrying the seal of approval of the American Medical Association and/or the American College of Surgeons.

As of January 1, some one hundred and forty Michigan institutions, representing General, Medical and Surgical hospitals, Tuberculosis Sanatoriums, as well as institutions for the care of the Nervous and Mental, had submitted contracts to participate in this program. The geographic distribution of these hospitals is such as to enable the veteran, in almost every instance, to obtain authorized hospital care in the immediate vicinity of his home environment.

In this regard, too, the Veterans Administration has embarked on a program of decentralization that will enable them to serve the veteran better and provide solutions to the veterans' problems rapidly and at a local level. Six sub-regional offices have been established at key points throughout Michigan:

Veterans Administration
Henry A. Mosher, Sub-Regional Manager
First National Bank Building
621 Ludington Street
Escanaba, Michigan

Veterans Administration
John Musgrave, Sub-Regional Manager
109 West Third Avenue
Flint 4, Michigan

Veterans Administration
Willard E. Asman, Sub-Regional Manager
540 Keeler Building
Grand Rapids, Michigan

Veterans Administration
R. K. Smith, Sub-Regional Manager
135 N. Westnedge
Kalamazoo 47, Michigan

Veterans Administration
Frank Campbell, Sub-Regional Manager
County Court House
Jackson, Michigan

Veterans Administration
Richard Calkins, Sub-Regional Manager
201 Board of Commerce Building
Saginaw, Michigan

These sub-regional offices are now staffed with personnel capable of reviewing the facts of the various veterans' cases, and on the basis of this information will, whenever necessary, issue instructions to Michigan Hospital Service and Michigan Medical Service to release authorizations that will provide the veteran with the needed medical and hospital care by the physician of the veteran's choice and the facilities of the hospital wherein his doctor has staff privileges.

Red-tape Reduced by MHS

Special reporting forms have been prepared that will enable the contract hospital or sanatorium to request extensions of the veteran's stay whenever the attending physician deems this necessary.

Similar forms permit the institutions under contract to report to the Veterans Administration any change in the patient's diagnosis apart from the one for which he was admitted.

Special rules have also been established to cover those instances when the emergent nature of the case has required the veteran's admission to the contract hospital before proper authorization has been procured.

With the co-operation of the Veterans Administration, Michigan Hospital Service has made every effort to reduce the paper work necessary to the functioning of this program to an absolute minimum.

Authorizations for the hospital care go forward to the veteran and the contract hospital the same day the Veterans Administration approves these cases. The necessary information pertaining to the veteran, such as name, address, claim number, length of stay authorized, and admitting diagnosis,

(Continued on Page 172)

Diabetes, diet and Globin Insulin . . .

THE ADVANTAGES of one-injection control of diabetes can, through adjustment of diet and dosage, be made available to the majority of patients requiring insulin. In view of the convenience and freedom afforded by the unique intermediate action of 'Wellcome' Globin Insulin with Zinc, the necessary adjustment is well worth while. Though not a complicated procedure, the regulation of carbohydrate balance warrants reiteration because of its importance:

SOME FACTS ABOUT DIETARY ADJUSTMENT: The distribution of carbohydrate in the meals must be adjusted in accord with the type of action exhibited by Globin Insulin, which is intermediate between regular and protamine zinc insulin. Proper carbohydrate distribution with proper insulin timing is essential; lack of balance may lead to poor control or to an erroneous impression of the characteristics of Globin Insulin.

A good carbohydrate distribution for the patient on Globin Insulin is to divide the total carbohydrate per day into 1/5 at breakfast, 2/5 at lunch and 2/5 at suppertime. This initial diet may be adjusted in accord with the indications of blood sugar levels and urinalyses. (For example, a low blood sugar before supper indicates too little carbohydrate for lunch or vice versa.)

Globin Insulin is ordinarily given before breakfast. Onset of action is usually sufficiently rapid to eliminate the need for a supplementary injection of regular insulin. However, the amount of breakfast carbohydrate should not be too large. The right amount, as well as the optimal time interval between the injection and breakfast, must of course be determined for each patient.

Since the maximum action of Globin Insulin usually occurs in the afternoon or early evening, hypoglycemia is sometimes noted at this time. As a guard against it, the carbohydrate content of the noon meal may be increased, or a midafternoon lunch provided. Thus the original distribution of 1/5, 2/5 and 2/5 might, for example, require adjustment to 2/10, 5/10 and 3/10 or to 2/10, 4/10, 1/10 and 3/10. Once the balance of carbohydrate intake and insulin timing has been established, the patient must be impressed with the importance of adhering to the regimen.

'Wellcome' Globin Insulin with Zinc is a clear solution, comparable to regular insulin in its freedom from allergenic properties. Available in 40 and 80 units per cc., vials of 10 cc. Accepted by the Council on Pharmacy and Chemistry, American Medical Association. Developed in The Wellcome Research Laboratories, Tuckahoe, New York. U.S. Patent No. 2,161,198. LITERATURE ON REQUEST.

'Wellcome' Trademark Registered

'WELLCOME' Globin Insulin WITH ZINC

BURROUGHS WELLCOME & CO. (U.S.A.) INC., 9 & 11 EAST 41ST STREET, NEW YORK 17, N.Y.

(Continued from Page 170)

are all on the form prepared by the veterans section of Michigan Hospital Service. This activity on our part relieves the business office of the hospital of a considerable amount of work. The heading of the bill for services rendered, which the hospital forwards to Michigan Hospital Service following the discharge of the veteran, is also prepared in the Michigan Hospital Service office, and accompanys the initial authorization to the contract hospital.

Contract hospitals are instructed to bill Michigan Hospital Service at the end of each calendar month, for the authorized care rendered the eligible veteran. These statements are then processed and sent to accounting with the intention of paying Michigan hospitals each month for veteran's care as authorized, rendered, and billed.

Tuberculosis Sanatoriums

The chief of the Tuberculosis Section, Veterans Administration, appealed to Michigan Hospital Service to approach the tuberculosis sanatoriums of Michigan and endeavor to obtain from them an assignment of some two hundred and fifty contract beds for the care of the tuberculosis veteran.

These sanatoriums in response to this appeal are now in the process of submitting contracts that will place more than four hundred beds at the disposal of the Veterans Administration, should this number be needed. This especially fine effort will be more than appreciated by those veterans needing this type of care, because the distribution of sanatoriums throughout the state, signifying their intention of co-operating in this need, is such as to enable the veteran, in most cases, to be hospitalized within the immediate vicinity of his home environment.

Two points of major interest are:

1. The Veterans Administration requires that this effort on the part of Michigan Hospital Service shall be without profit to them.

2. These contract hospitals have entered into an agreement with the Veterans Administration, through Michigan Hospital Service, to provide hospital care to the eligible veteran on a basis of *cost,* and they are required under the terms of the contract to provide hospital service in any needed quantity *without any additional charge to the veteran,* accepting as *payment in full* reimbursement from the Veterans Administration on the basis of the per diem cost as determined through their statement of operating expenses reported to this governmental agency.

Name .....

Office Add..... City.....

Res. Add. ..... City.....

I hereby pledge to the

MICHIGAN FOUNDATION FOR MEDICAL AND HEALTH EDUCATION
2020 Olds Tower, Lansing 8, Michigan, for the twelve-month period
beginning March 1, 1947, the sum of

TOTAL PLEDGE	PAID HEREWITH	BALANCE DUE
$	$	$

My contribution is

Please Check Your Choice ☑

(1) In Cash ☐ to be paid in the total sum ☐ or in annual payments of $.....

or **(2) In War or Victory Bonds** ☐ to be paid in the total sum ☐ or in annual payments of $.....

or **(3) In Life Insurance** ☐

or **(4) As a Memorial** ☐ to the memory of:

.....

or **(5) In my Will** ☐

SIGNATURE .....

Men and Amino Acids

EMIL FISCHER—1852-1919

Emil Fischer—brilliant investigator, profound thinker, noted teacher—made possible, by his researches, most of the greatest advances in protein chemistry. His versatility and inspired imagination, coupled with a genius for experimental research, contributed basic knowledge of the greatest value to nutritional science. He did fundamental work on purines and sugars; laid the foundations of enzyme chemistry; and made stereochemistry a tool of research. He separated the amino acids from protein hydrolysates by his epoch-making distillation method; and not only ascertained many of the constituent amino acids of protein molecules but recombined them into synthetic peptides approximating natural substances, by virtue of his recognition of the peptide linkage.

His brilliant work brought him recognition from most of the important scientific societies of the world. The Royal Society awarded him the Davy Medal and elected him a foreign member, and in 1902 he became Nobel Laureate in Chemistry.

The Arlington Chemical Company

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Postgraduate Continuation Courses

WAYNE UNIVERSITY COLLEGE OF MEDICINE

Quarter begins on March 3, 1947

These courses are open to all qualified persons.

Veterans who are not residents in a Detroit hospital should make arrangements for tuition, as provided by the GI Bill, with Mr. Don Palmer, Veteran Administrator at Wayne University.

Registration for these courses can be made in the office of the Director of Graduate Medical Education at the College of Medicine any time before March 3, 1947.

Title of Course	*Place*	*Time*	*Fee*
	Anatomy		
Regional Anatomy	College of Medicine		
Trunk (Begins Feb. 19)	(Limit 50)	Wed. 1-5	$50
Extremities and Back	(Limit 50)	Thurs. 2-5	50
Head and Neck	(Limit 50)	Fri. 1-5	50
Problems in Neurology	College of Medicine	Thurs. 3-5	25
	Bacteriology		
Immunology and Virology	College of Medicine	Wed. 1-5	$35
	Physiological Chemistry		
Nutrition	College of Medicine	Mon., Wed., Fri. 11-12	$25
Seminar	College of Medicine	Wed. 4-5	10
Intermediary Metabolism of the Lipides	College of Medicine	Thurs. 4-5	10
	Dermatology		
Neoplasms of the Skin	College of Medicine	Tues. 6-9	$35
Seminar	Receiving Hospital	Wed. 10-11:30	10
Conference on Venereal Diseases	Social Hygiene Clinic	Thurs. 3-4:30	10
	Medicine		
Medical X-Ray Conference	(a) Receiving Hospital	Tues. 11-12	$10
	(b) Wayne County Gen.	Fri. 1-2	10
Gastroenterology Clinic	Receiving Hospital	Wed. 1-2	10
Therapeutic Conference and Hematology Clinic	Receiving Hospital	Thurs. 11-12	10
Medical Pathologic Conference	(a) Receiving Hospital	Fri 11-12	10
	(b) Wayne County General	Thurs. 11-12	10
Diagnostic Conference	Wayne County General	Tues. 4-5	10
Beginning Electrocardiography	Wayne County General	Fri. 11-12	10
	Pathology		
Advanced Hematology	College of Medicine	Mon. 1-5	$35
(Limited to 5 who had Beg. Hematology)			
Gynecologic Pathology	College of Medicine (Limit 35)	Wed. 1-5	35
Pathology of Children's Diseases	College of Medicine (Limit 25	Fri. 1-5	35
Beginning Hematology	College of Medicine	Fri. 1-5	35
	Pharmacology		
Seminar in Pharmacology	College of Medicine	Tues. 3:45-5	$10
Physical Medicine	Grace Hospital	Thurs. 1-5	35
	Physiology		
Blood	College of Medicine	Tues. 4-5 Fri. 3-5	$25
	Radiology		
Seminar Conference in Radiology	Affiliated Hospitals	Alternate Mondays 6:30-8	$10
	(First session March 3)		
	Surgery		
Seminar in Surgery	College of Medicine (Limit 20)	Thurs. 4-5	$10

The "One Prescription" Food for Bottle-fed Infants.....

- for full-term or premature infants
- from birth to end of bottle feeding
- complemental to mother's milk, or exclusively

LIQUID

POWDER

Start with either and change from one to the other, to suit individual requirements. Powder form is especially convenient when traveling.

Many physicians prescribe Baker's Modified Milk for the majority of their bottle-fed infant cases. They prefer Baker's Modified Milk because few cases require any change at any time, except increased quantity as the baby grows older.

Baker's Modified Milk is a time-saver for the doctor and for the mother, for it is a completely prepared food that requires no complicated feeding directions (just dilute with water, previously boiled) and therefore reduces the possibility of error.

Among the many other reasons for the wide prescription of Baker's Modified Milk are:

Baker's Modified Milk is a complete food (except for Vitamin C) that closely conforms to human milk in nutritional results . . .

. . . is well tolerated by both premature and full-term infants . . .

. . . may be used either complemental to or entirely in place of human milk . . .

. . . is helpful in correcting regurgitation, constipation, loose or too-frequent stools . . .

Just leave instructions at the hospital. The obstetrical supervisor will be glad to put your next bottle-fed infant on Baker's Modified Milk.

• Baker's Modified Milk is made from tuberculin-tested cows' milk in which most of the fat has been replaced by animal and vegetable oils with the addition of lactose, dextrose, gelatin, iron ammonium citrate, vitamins A, B_1 and D. Not less than 400 units of vitamin D per quart.

Complete information and samples gladly sent to physicans on request.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods and Nutrition

BAKER'S MODIFIED MILK

THE BAKER LABORATORIES, INC., CLEVELAND, OHIO

BRANCH OFFICES: SAN FRANCISCO, LOS ANGELES and DENVER

"Socialized Medicine--Bad Medicine For You"

Michael Wright, in *Better Homes and Gardens* for January, 1947, writes an illuminating article under the above heading. The sub-head states, "America might better provide for proper health education instead of a socialized system that can lead only to inferior medical care for everybody."

Quotable paragraphs abound in this excellent exposé of the "medical planners," such as the following:

"In most all communities, except a few rural ones, there are agencies, clinics, and hospitals that provide care entirely free or at costs the people can afford.

"The trouble was not that most of these men could not get care. It was that they were afraid. That they were lax. They placed other things first —wrong things. Many a man will take better care of his car than of himself. Let the motor pound or the rear end lump, and he heads straight for the garage, pays a big bill for the cure. But this same man will himself pound and lump along for months, dosing with vitamins, taking pills to correct his 'acid condition.' Anything to forestall the evil day of going to the doctor who may tell him what he dreads to hear—goiter, ulcers, cancer, surgery, something.

"It takes more than prepaid care to bring a man health.

"As for periodic checkup, the attitude is: Who wants to go to the doctor when there's nothing wrong? He'll think you're a nut, a neurotic, a hypochondriac.

"There are many, of course, who actually are. When their bill is already paid by socialized medicine, they run to the doctor with everything. They want all that is coming to them. They call their doctor at all hours of day or night for mere trivialities. 'I am very sick. You must come right away.' The doctor becomes discouraged, disgusted. And soon he comes to think: 'What does it matter what kind of medicine I practice?'

"Rather than socializing medicine, would it not make more sense to put all our education, all our production and distribution of food, houses, and clothing under the thumb of the social security administrator? Then, through pay-roll deductions, we might guarantee everyone a quart of milk a day, steak, a car, and a Cape Cod cottage.

"Or is that what Wagner, Murray, and Dingell are really up to?

"A person who needs help should have it. So far as possible he should make his own way. Beyond that, he should have help. But not in a manner that will tear down the quality of medical care to the rest of us.

"Not in a manner that will destroy private practice.

"Not in a manner that will destroy the voluntary hospital system.

"Not in a manner that will give one man control over medical research and education.

"Not in a manner that will bind the physician in political slavery.

"Not in a manner that makes men leeches, hypocrites, and servile to their government, without the will to fight unceasingly for freedom."

STOP—LOOK—LISTEN

STOP telling the patient there is nothing wrong with him but nerves. Don't say, "Go home and forget it."

LOOK for the facts as the patient sees them.

LISTEN attentively to patient's story.

* * *

Parents place too high a premium on submissiveness in their children.

* * *

The type of complaint is often not so important as the type of person who has the complaint.

Youth is always looking for new places and experiences. He is curious! Help him. Plan with him. Direct him.

* * *

Some good nose and throat physicians are courageous enough to tell the patient that the sinuses are not the trouble, and to refer him to a psychiatrist.

* * *

A common cause for divorce is a lack of emotional preparation for marriage.

* * *

A child's adjustment to life is related to his parents' adjustment—to marriage—to parenthood—to social position.

* * *

Do not wait for the child to outgrow his misbehavior. He needs lots of help.

MSMS Mental Hygiene Committee.

VITA-AMINO GRANULES

(Hartz)

Chocolate flavored—pleasant to take

Containing the essential amino acids calculated on a 16% nitrogen basis.

Arginine	3.5%	Histidine	1.5%
Lysine	6,5%	Tyrosine	4.0%
Tryptophane	1.0%	Phenylalanine	3.5%
Cystine	1.6%	Methoinine	2.0%
Threonine	3.3%	Leucine	6.4%
Isoleucine	4.7%	Valine	4.8%

It also contains in each 100 grams Thiamine .7 mg., Riboflavin 1 mg., Niacin 5 mg., Panthothenic Acid 2.5 mg., Pyridoxine .375 mg., Biotin .05 mg., Folic Acid .2 mg., Choline 50 mg.

CHIEF INDICATIONS

The administration of Vita-Amino Hartz is intended to be oral and can be used as an addition to the daily menus in drinks or added to breakfast foods. Suitable protein hydrolysates given by mouth have been reported useful in the following conditions:

To provide acid binding molecules for patients with peptic ulcers or gastric hyperacidity and in addition to provide building material of damaged tissue. Also indicated in other types of ulcers and bedsores for speeding the healing of such conditions.

To provide building material for Antibody production in cases of bacterial infections where ordinary protein intake is restricted.

In providing readily assimilable nitrogen for patients with liver and kidney diseases.

For increasing the nitrogen intake of the aged and convalescent.

To maintain nitrogen equiligrium during periods of nitrogen loss due to diarrhea.

In the correction and prevention of edema due to protein insufficiency.

To replace the nitrogen losses due to severe burns.

To supplement protein intake during pregnancy.

Supplied in 8 oz. and 1 lb. Sizes

For Convenient Dispensing

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PHARMACEUTICAL MANUFACTURERS • MEDICAL SUPPLIES

You and Your Business

WILLIAM S. McNARY APPOINTED MHS EXECUTIVE VICE PRESIDENT

The appointment of William S. McNary as its permanent executive vice president and general manager by the trustees of Michigan Hospital Service, has been announced by George M. Welch, president. The new appointment was effective February 1, 1947.

McNary, formerly executive director of Colorado Hospital Service, brings to the Michigan Plan a tremendous amount of business and hospital experience. A graduate of the University of Colorado in business administration, he was business manager of Colorado General Hospital until he resigned in 1938 to become executive director of the Blue Cross Plan in that state, a position he has held up to the present time. In 1943 McNary was elected to the important nine-man Blue Cross Commission, a policy-making body for the eighty-seven Blue Cross Plans in the United States, Canada and Puerto Rico. He is also chairman of its Subcommittee for National Individual Enrollment.

As general manager of the Michigan Hospital Service, McNary is directing the third largest Blue Cross organization in the United States. Present enrollment in the Michigan Plan exceeds 1,165,000.

John W. Paynter, acting general manager on loan from the J. L. Hudson Company, returned to his position as assistant controller of that organization as soon as the permanent general manager assumed his new duties.

POSTGRADUATE COURSE IN RADIOLOGY

One hundred radiologists will be selected to attend the postgraduate courses in radiology to be conducted March 30 through April 4 in Philadelphia by the American College of Radiology. Preference will be given to radiologists who served in World War II. Second preference will be given to qualified applicants who were unable to obtain admission to last year's course in Philadelphia. The course is sponsored jointly by the American College of Radiology and the Philadelphia Roentgen Ray Society.

Because of the popularity of the course given in Philadelphia last year, many radiologists were unable to be enrolled. Numerous requests for a second similar course have prompted the committee to sponsor it again this year.

There are two main considerations which have impelled the committee to undertake this program:

Although national and local scientific societies in the specialty of radiology have maintained a consistently high standard in their regular meetings, numerous inquiries have indicated an obvious need for intensive courses of a more academic nature. Also, veteran medical officers have been felt to be in need of an intensive review before returning to private practice. Many of these men were denied the opportunity for normal clinical practice or study which would keep them abreast of the rapid progress in the specialty of radiology.

Some of the subjects to be studied are certain neoplastic and inflamatory diseases, carcinoma of the head and neck, dosage calculation and tumor sensitivity in radiation therapy, carcinoma of the breast, blood and hemopoetic diseases, carcinoma of the genital and urinary tract, benign and malignant diseases of the skin.

PROGRESS REPORT OF WAYNE MEDICAL SCIENCE CENTER

1. Establishment, in October, 1943, of a medical center headquarters office with a full-time executive secretary.

2. Incorporation, in November, 1943, of the Medical Science Center of Wayne University as a Michigan nonprofit corporation. Thus was provided an agency with which to operate, receive money, and make and keep commitments.

3. Raising of a Promotion Fund of approximately $80,000, of which more than $69,000 was subscribed by the Medical Science Center's Board of Directors, with which to engage fund-raising counsel, conduct the Medical Science Center's headquarters office, and administer donations. Thus none of these costs has been charged against donations. Every cent of donated money has been or will be used for the purpose specified by the donor.

4. Selection of a fifteen-block site east of the Art Center as best for Medical Science Center purposes.

5. Obtaining of approval of this site from the Board of Education, the City Plan Commission, and Wayne University.

6. Appointment of Smith-Hinchman and Grylls, Inc., as Medical Science Center architects.

7. Preparation by the architects of a master plan encompassing all future units of the Medical Science Center.

8. Employment of the American City Bureau, of Chicago, as fund-raising counsel. From May through December, 1944, the Medical Science Center used from one to three American City Bureau staff men, plus secretarial help. These experts conducted a city-wide survey and reported that the project was both sound and badly needed, and that the money could be raised in a series of cycles over a ten-year period. They helped crystallize plans, prepared prospect lists, and did much other preliminary work that will be invaluable when campaign plans are resumed.

9. Employment of Dr. Basil C. MacLean, director of Strong Memorial Hospital, Rochester, New York, an internationally recognized authority on the building, equipping and operation of hospitals and similar units, as medical consultant to the Medical Science Center.

(Continued on Page 180)

mortality reduction in intestinal surgery

Clinical reports continue to substantiate the *exceptional effectiveness* of 'Sulfasuxidine' *succinylsulfathiazole* as an enteric bacteriostat in intestinal surgery. After employing the drug, together with other appropriate measures, in the preoperative preparation of 50 patients for intestinal anastomosis, two distinguished clinicians concluded:

> **"Preparation with succinylsulfathiazole and aseptic anastomosis are factors in reducing the mortality rate."***

'Sulfasuxidine' *succinylsulfathiazole* is effective also in the treatment of acute or chronic bacillary dysentery, as well as the carrier state of the disease, and in ulcerative colitis. Supplied in 0.5-Gm. tablets in bottles of 100, 500 and 1,000 as well as in powder form in ¼-pound and 1-pound bottles. Sharp & Dohme, Phila. 1, Pa.

SHARP & DOHME

*Surg., Gynec. & Obst. 81:593, December, 1945

'SULFA SUXIDINE'

Succinylsulfathiazole

PROGRESS REPORT OF WAYNE MEDICAL SERVICE CENTER

(Continued from Page 178)

Since October, 1944, Dr. MacLean and his associate, Mr. Lawrence J. Bradley, have been of vast help in general planning.

10. Establishment, in February, 1945, of the School of Occupational Health, as a part of Wayne University, and the employment of Dr. Raymond Hussey as its dean.

11. Granting of $12,500 for the purchase of equipment for the Department of Anatomy of the Wayne University College of Medicine.

12. Complete revision of plans for the Medical Science Center by a Wayne University Planning Committee headed by Dr. David D. Henry. This revision was made necessary by the recommended enlargement of Medical Science Center units and program. The work of revision extended throughout all of the calendar year of 1945. The Planning Committee achieved it in collaboration with the Medical Education Committee of the Wayne County Medical Society and with the faculties of Wayne University colleges and departments that are concerned with the Medical Science Center. The Planning Committee deserves highest commendation for its careful and thorough work. So do the architects, and Dr. Basil C. MacLean, medical consultant to the Medical Science Center.

13. Thorough canvass of prospective donors of large "challenge gifts" on which a campaign for the goal of the first cycle—approximately $16,000,000—could be based. While, as has been pointed out, no substantial "challenge gifts" are obtainable at this time, a thorough groundwork has been laid and further approaches to these same prospects will be made at a future and favorable time.

PUBLIC RELATIONS PROGRAMS GET UNDER WAY

Public Relations programs were established in many states during the past year. To facilitate the work a number of state societies have established full time public relations departments. Each society is urged to develop this field of activity. Available information concerning definite P. R. programs may be obtained from the following:

G. H. Saville, Ohio State Medical Association, 79 East State Street, Columbus.

Jack Meadors, South Carolina Medical Association, 105 West Cheves Street, Florence.

James G. Burch, Connecticut State Medical Society 258 Church Street, New Haven.

Dwight Anderson, Medical Society of the State of New York, 292 Madison Avenue, New York.

Hugh Brenneman, Michigan State Medical Society, 2020 Olds Tower, Lansing.

Henry S. Johnson, Medical Society of Virginia, 1200 East Clay Street, Richmond.

Frank Lais, Jr., Louisiana State Medical Society, 1430 Tulane Avenue, New Orleans.

—*Bulletin Council on Medical Service,* AMA.

Communication

To the Secretaries of all Component County Medical Societies:

The following resolution was presented to the House of Delegates of the American Medical Association at its Supplemental Session held in Chicago, December 9 to 11, 1946. This was referred to the Reference Committee on Legislation and Public Relations and the Reference Committee recommended to the House that it be referred to the Board of Trustees of the Association for future action. The House of Delegates adopted the recommendation of the Reference Committee.

WHEREAS, Public relations, as pertains to organized medicine, has a most important field of effort in reaching and giving information to and receiving suggestions from the rank and file of doctors who give medical service to the public the country over; and

WHEREAS, Efforts in this direction have been so successfully carried on by the secretaries' conferences sponsored by several of the state medical societies; and

WHEREAS, There is no national group at present functioning in this capacity; therefore be it

RESOLVED, That the American Medical Association sponsor a national conference of officers of county medical societies which shall meet yearly just preceding the annual session of the House of Delegates of the American Medical Association for the purpose of bringing to the annual session the diverse problems of the various localities, the exchange of ideas which would be helpful to the state conferences, in such matters as voluntary health insurance plans, hospitalization plans, construction of new hospitals in needed places, and improvement in medical facilities, rural health activities, nursing activities and the activities of the various Councils of the American Medical Association.

The Board of Trustees after consideration of the resolution plans to have a meeting of this nature in Atlantic City, New Jersey, probably on Sunday, June 8, 1947.

This letter is for your information so that should you plan to attend the Centennial Celebration at Atlantic City, you can arrange to arrive one day early for the Sunday meeting. I shall write you later concerning the definite hour and place of the meeting.

Sincerely,

GEORGE F. LULL, *Secretary,*
American Medical Association.

President Truman's Letter to Congress

"Over a year ago I presented to the Congress my views on a national health program. The Congress acted on several of the recommendations of this program—mental health, the health of mothers and children and hospital construction. I urge the Congress to complete the work begun last year and to enact the most important recommendation of the program—to provide adequate medical care for all who need it, not as charity, but on the basis of payments made by the beneficiaries of the program."

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Treatment of H. Influenzae Meningitis

By H. E. Alexander, M.D.
New York, New York

During the past ten years, antibacterial agents have become available in such rapid succession that there has scarcely been sufficient time for clinical evaluation before the discovery of new ones. The conclusions expressed in many publications and the efforts of our daily press have been responsible for creating the impression that each new agent surpasses the older ones which may therefore be discarded. It would seem profitable to take stock of our factual data on the efficacy and indications for use of therapeutic agents in bacterial infections. This appears to be especially pertinent in treatment of H. influenzae infections, which will be the topic of this paper.

While severe infections caused by typable H. influenzae occur rarely in adults they constitute one of the frequent serious problems in pediatrics. The clinical pattern, however, is the same in all age groups, with meningitis, obstructive infections of the respiratory tract, and pneumonia being responsible for most of the severe varieties; an occasional example of suppurative arthritis is seen, often associated with osteomyelitis, and rarely pericarditis is caused by H. influenzae. Bacteremia is characteristically present in all of these clinical varieties. Type *b* is responsible for virtually all severe H. influenzae infections; rarely Types *a* and *f* are causes. A survey of the distribution of typable H. influenzae in the Babies Hospital population over a five-year period indicates that febrile upper respiratory infection of a comparatively mild nature occurs as frequently as the severe varieties just mentioned and that very occasionally a well child harbors the organism. There is reason to believe that the last group represent carriers who have overcome a previous infection with H. influenzae. Nontypable varieties, normally present in the nasopharynx of well children and adults, very occasionally cause bacteremia and meningitis in young infants and subacute bacterial endocarditis in adults.

The first specific therapy used on a scale sufficient for evaluation was a horse antiserum, produced by Fothergill in 1931, for treatment of meningitis. In over 200 cases treated intravenously and intrathecally for many days, 84 per cent died. Sulfanilamide made its appearance in 1936 and was responsible for only an occasional recovery from influenzal meningitis. Sulfapyridine, which supplanted it in 1939, was a superior agent as judged both clinically and experimentally *in vitro* and *in vivo*. The clinical response to this sulfonamide was so superior to previous treatment that many responsible investigators considered the treatment of influenzal meningitis solved.

In 1938 there was adopted at the Babies Hospital a treatment for H. influenzae meningitis which combined the inhibitory action of sulfonamides in conjunction with a rabbit antiserum specific for Type *b* H. influenzae. All of the knowledge then available of the biology of the influenza bacillus was applied in the production of this antibody. In our attempts to use this therapy most efficiently, certain facts became clear. The

The work reported in this communication was supported by grants from the Commonwealth Fund.

Presented at the eighty-first annual session of the Michigan State Medical Society, Detroit, September 25, 1946.

TABLE I. SCHEDULE OF DOSAGE BASED ON SPINAL FLUID SUGAR

Spinal Fluid Sugar (Mg. per cent)	Mg. Antibody Nitrogen Indicated
15	100
15 to 25	75
25 to 40	50
over 40	25

dose of antibody needed varied with the severity of infection. Therefore, some objective criterion of severity was essential. To relate the size of the dose to severity of infection, a method was needed for measurement of antibody in a given volume of serum. Moreover, the sufficiency of the original dose decided upon required confirmation.

1. The best index of severity of infection proved to be the concentration of sugar in the spinal fluid withdrawn before treatment; the lower the concentration, the greater the severity.

2. Heidelberger showed that the antibody in the rabbit antiserum could be measured by the quantitative chemical method for determining agglutinin and precipitin nitrogen. Mouse protection tests showed that the protective element in the antiserum was actually the anticarbohydrate antibody which this method measured in milligrams of antibody nitrogen per c.c. Thus it was possible to formulate a quantitative approach to treatment as shown in Table I.

3. This plan aimed to introduce at one time the amount of antibody necessary for recovery. Nonetheless, it was necessary to check its sufficiency. The capsular swelling capacity of the patient's serum following treatment proved to be a good guide. This test was performed daily through the period of activity of infection, and unless it could be shown that the patient's serum contained an excess of free antibody sufficient to cause capsular swelling of the organism when diluted 1:10, another dose of antiserum was administered (25 to 50 mg.).

This treatment was greatly simplified when it was learned that prompt recovery followed introduction of this antiserum by the intravenous route only. In a given case, sodium sulfadiazine is introduced by the subcutaneous route in a quantity equivalent to 0.1 gm. per kg. as soon as diagnosis of Type *b* H. influenzae is made. A continuous intravenous drip is set up immediately if there is urgent need of fluids, and 5 per cent glucose in saline (approximately 30 c.c. per kg.) is administered over the next hour. Then the quantity of antibody, calculated according to Table I is diluted in physiologic saline (10 c.c. per kg.) and added to the reservoir of continuous drip apparatus. The speed is so regulated that the diluted antibody will be administered in two hours. Sulfadiazine is given orally as soon as feasible and continued for seven days after the first sterile spinal fluid is obtained. No additional serum is given unless the capsular swelling test shows inadequate excess of antibody in the patient's serum.

When patients are treated early with the combined therapy of sulfadiazine and type-specific rabbit antibody according to the principles outlined, the response has been so consistent that it is possible to predict not only the outcome but the course of recovery. Even in the fulminating group in which the meningitis progresses so rapidly that the spinal fluid sugar falls to less than 15 mg. per cent within twenty-four hours of onset, prompt recovery can be expected in all cases if sufficient antibody is administered in the initial dose. Actually only 80 per cent of the ninety patients treated according to this regime recovered, the failures being attributable to delay in diagnosis and to unwarranted confidence in the value of sulfonamides alone.

Nonetheless, it is clear that a certain proportion of patients do recover on sulfonamides alone. Our own clinical experience suggests that this fraction is small, and we are inclined to believe that the published records of isolated examples of cure with sulfonamides alone convey a false optimism as to the true efficacy of these agents. Over one-fourth of our cases received serum only after extended periods of unsuccessful sulfonamide therapy in other hospitals. Only two-thirds of this group recovered when serum was added; in virtually all of these, the infection had been kept under control during treatment but had not been eliminated, for on withdrawal of the drugs recrudescence occurred. This experience led us to study the criteria for selecting those patients who might be expected to recover on sulfonamides alone, and for this purpose we made a comparison of the protective value in mice of available sulfonamides alone, of antiserum alone and of the best sulfonamide and serum in conjunction. The results established the fact that the efficiency of sulfadiazine, the most effective of three sulfonamides tried, was dependent upon the size of the

bacterial population whether in the test tube or mouse, and suggested that it might be able to cure meningitis if used early in mild infections. Whereas the protection with sulfonamide alone never exceeded 10,000 minimum lethal doses (M.L.D.), when serum was added the mice withstood 1,000-000 M.L.D.

These observations resulted in the adoption of certain criteria for selection of patients who might be expected to recover on sulfadiazine alone. When meningitis has been present for only twenty-four hours, the infection is judged mild, as indicated by a concentration of sugar in the spinal fluid of 40 mg. or more per 100 c.c., and when the clinical features are in keeping with this, the use of sulfadiazine alone is justified initially. If *in vitro* tests indicate usual sensitivity of strain, it is believed that the drug alone may be continued without risk, provided clinical improvement ensues, and provided the spinal fluid shows the infection to be under control, with cultures sterile forty-eight hours after the start of chemotherapy. A minimum of two weeks of such treatment is essential for elimination of infection. It is of interest that, during a period when approximately thirty patients were treated, only two fulfilled the criteria which justified the use of sulfonamides alone.

It must be emphasized that these therapeutic recommendations refer only to meningitis. Experience with the other varieties of severe infections, pneumonia, obstructive infections of the respiratory tract, arthritis, et cetera, is much less extensive, but certain facts are clear. Sulfadiazine alone constitutes an effective treatment for H. influenzae pneumonia in older children. In infants under one year of age, especially when pneumonia is accompanied by empyema, the frequency of development of a complicating meningitis has led to the policy of using both antiserum and sulfadiazine. The characteristic clinical syndrome of epiglottis, causing respiratory obstruction, responds promptly to sulfadiazine alone in the majority of patients, after tracheotomy. Only three of our sixteen patients have required antiserum in addition. When H. influenzae produces pyarthrosis and osteomyelitis, the possibility of injury to epiphysis and cartilage is so great that treatment should aim for the most rapid termination of infection. This is best accomplished by the simultaneous use of all effective therapeutic agents.

About a year ago, streptomycin became available. The demonstration of marked antibacterial activity of this antibiotic on a number of other Gram-negative bacilli by Waksman and others suggested its trial against H. influenzae. Therapeutic trial was undertaken only after laboratory investigations had explored the range of sensitivity, *in vitro* and *in vivo,* of a representative number of strains of Type *b* H. influenzae. A simple *in vitro* test proved adequate for this purpose and, when used for testing cultures grown from biologic fluids after the start of treatment, served also as a reliable guide to the therapeutic efficacy of streptomycin in a given patient with influenzal meningitis. The results demonstrated a marked degree of sensitivity of this organism to streptomycin both *in vitro* and *in vivo.* Before exposure to streptomycin the MEC* of over 50 strains ranged from 0.8 to 10.8 units per c.c. and the MED† of five of these varied from 19 to 78 units per mouse. After exposure to streptomycin, the strains in two patients exhibited resistance to more than 1,000 units per c.c. Likewise, sixteen originally sensitive strains, subcultured in gradually increasing concentrations of streptomycin, after periods of one to three weeks thrived in concentrations exceeding 525 units per c.c. Results from mouse protection tests showed a high degree of correlation with those obtained *in vitro,* as shown in Table II. Whereas five strains exhibiting MEC between 0.8 and 10.8 units per c.c. showed MED of 19 to 78 units per mouse, those strains which resisted high concentration *in vitro* (1,000

TABLE II. RELATION BETWEEN MEC* ON LEVINTHAL AGAR AND MED† SUFFICIENT TO PROTECT MICE AGAINST TWENTY MILLION ORGANISMS PER MOUSE

Strain Number	Sensitive Strains		Resistant Strains	
	MEC	MED	MEC	MED
1	1.1	39.0		
1a			525.0	> 630.0
1b	13.0	39.0		
2	1.6	19.5		
2a			73.0	315.0
3	1.1	19.5		
3a			525.0	> 1,575.0
4	0.8	19.5		
4a			1,078.0	> 1,575.0
5	2.8—4.4	78.0		
5a			1,000.0	> 5,000.0

*MEC—Minimum effective concentration in vitro units per c.c. of culture media.

†MED—Minimum effective dose units per mouse required for protection of 50 per cent of animals.

*MEC—Minimal concentration of streptomycin which, when incorporated in Levinthal agar, completely inhibits growth of inoculum of three to 1,700 million organisms after an incubation period of forty-eight hours.

†MED—The smallest single dose of streptomycin which will protect 50 per cent or more of mice, each of which received twenty million organisms (1,000,000 M.L.D.).

TABLE III. USE OF STREPTOMYCIN IN ELEVEN PATIENTS

Case	Streptomycin Concentrations Units Per c.c.		Streptomycin Dose and Route Units x 1000 q 24 hrs.			MEC[5] Units Per c.c.
	Blood[1]	Spinal Fluid[2]	IM[3]		IT[4]	
1.	8.9—30.6	9.1—20.4	C.D.	20 per lb.	50	2.7
2.	5.1—10.1	— —	q3h	20 per lb.	25	2.6
3.	4.2— 8.5	11.5— 5.1	q3h	20 per lb.	25	4.9
4.	10.1—19.1	11.8—20.0	q3h	20 per lb.	25	1.6
5.	6.2—14.6	6.2— 6.0	q3h	20 per lb.	50	2.8
6.	5.5—14.5	5.0—28.0	q3h	20 per lb.	25	2.8
7.	3.3— 6.5	8.5—	q3h	20 per lb.	25	4.4
8.	7.3—22.0	4.9—16.3	q3h	20 per lb.	30	7.5
10.	5.8—12.2	5.1—12.1	C.D.	20 per lb.	50	2.5
11.	9.3—10.5	9.3— 9.6	q3h	20 per lb.	25	1.6
12.	7.5— 9.8	11.1—	q3h	20 per lb.	25	4.4

[1]Specimen collected daily at irregular intervals when intramuscular dose was given by continuous intramuscular drip (C.D.). When streptomycin was given every three hours (q3h) the blood was withdrawn three hours after the last dose.

[2]Spinal fluid concentrations represent those found twenty-four hours after intrathecal dose listed.

[3]IM—Intramuscular.

[4]IT—Intrathecal.

[5]MEC—Minimal effective concentration of streptomycin necessary to completely prevent growth on Levinthal agar in forty-eight hours.

units per c.c.) proved to be equally resistant in mice. Doses as high as 5,000 units per mouse failed to protect 50 per cent of the mice.

Despite the agreement between the *in vitro* and *in vivo* tests, neither method enabled us to select in advance the patients whose strains became resistant after the beginning of streptomycin treatment. Our therapeutic results suggest that it is the severity of infection, and therefore presumably the size of the bacterial population, which determines whether the strain from a given patient will exhibit resistance. This is in line with the view held by most authorities that large populations of all strains, demonstrated as sensitive by ordinary *in vitro* tests, contain a small number of resistant organisms.

While these procedures fail to detect traits of resistance in the original strains, their use in determining the sensitivity of organisms cultivated from patients after the start of streptomycin treatment has provided a clear indication of the efficacy of this antibiotic in the patients from whom the strains were isolated. In the group of patients in whom streptomycin treatment proved successful, all strains isolated from spinal fluid or from the respiratory tract after the beginning of treatment were shown to be sensitive. On the other hand, treatment was unsuccessful in two patients whose strains exhibited marked resistance during streptomycin administration.

Twenty-five patients have received streptomycin either alone or in conjunction with other agents. The daily intramuscular dose, given either by continuous intramuscular drip or divided into eight doses injected every three hours, was equivalent to 20,000 units per pound body weight. All patients received daily intrathecal injections in 25,000 to 50,000 units quantities. The duration of treatment was only five days for most patients. This period appears to be adequate for all. The occurrence of eighth nerve deafness in a significant number of patients treated for periods longer than one week makes it a serious responsibility to determine and to use the shortest period of treatment which is effective. Table III lists, for each patient of the eleven studied, the variations of streptomycin in the blood and spinal fluids, and, for comparison, the MEC of the individual strains.

The results of treatment of the twenty-five patients receiving streptomycin alone or in conjunction with other agents are summarized in Table IV. Each patient is classified according to the severity of his infection and the therapeutic agent or agents used. Severity of infection was judged by two standards, clinical signs and the concentration of sugar in the original spinal fluid. In the cases of mild or average severity, the level was above 30 mg. per cent in all but one patient, whose value was 24. In the severe group, whether the infection was in chronic, or early stage, the concentration of sugar in spinal fluid before treatment with streptomycin was 15 mg. per cent or below. The patients are divided into four groups according to the therapy received: streptomycin alone; streptomycin alone for four days, at which time type-specific antiserum and sulfadiazine were added; the four who received streptomycin after unsuccessful treatment with type-specific antiserum and sulfadiazine; and those treated with all three agents initially. The result of treatment is recorded under *R* for complete recovery, *S* for those who survived but who exhibited serious cerebral injury and *D*

TABLE IV. SUMMARY OF TREATMENT OF TWENTY-FIVE PATIENTS

No. Patients Treated	Severity of Infection	S.M.[1] Alone			Serum After 4 Days of S.M.			S.M. After Unsuccessful Serum and Sulfa			S.M., Serum, Sulfa Initially		
		R[2]	S[2]	D[2]	R	S	D	R	S	D	R	S	D
13	Mild or average	12						1					
8	Severe chronic			2		2		1	1	1	1		
4	Severe early				1						3		

Total Cases: R—19 S—3 D—3

[1]S.M.—Streptomycin.
[2]R—Recovered. S—Survived. D—Died.

for those who died. All of these twenty-five patients had received sulfadiazine at home or in other hospitals before institution of streptomycin therapy, with one exception, No. 12, in whom the antibiotic was unsuccessful. It can be seen that when the infection is of mild or moderate severity, streptomycin alone brings about complete recovery. While, on the whole, clinical improvement was less rapid than that seen following serum treatment, the changes in the spinal fluid, indicating clearing of infection, appeared just as promptly as those seen following serum therapy. In nine of the twelve patients who recovered, the spinal fluid cultures proved sterile twenty-four hours after initiation of streptomycin therapy; in the other three, after forty-eight hours. The return to normal of the chemical constituents of the spinal fluid was equally rapid. When the disease is severe and other therapeutic agents are not used to supplement streptomycin until after four days or longer, the results are very disappointing. Four patients received streptomycin for the first time after unsuccessful serum and sulfadiazine treatment in other institutions. All but one were adequately treated. Of these, one died, one survived but showed serious mental deterioration, and two recovered completely. In this group of patients with severe infections, the disappointing results of treatment with the two forms of therapy used separately led us for a period to adopt the policy of administering all three agents initially: streptomycin, type-specific antiserum, and sulfadiazine. Four patients with severe infections have been treated according to this plan; all four recovered and appear to be normal in physical and mental development, but since two were under six months of age at the time of their illness, a longer period of observation is necessary. There is reason to believe from our recent experimental evidence that sulfadiazine in conjunction with streptomycin will prove successful in a portion of the severe cases. Criteria for selection are being explored.

TABLE V. SUMMARY OF PROTECTIVE POWER OF THERAPEUTIC AGENTS IN MICE

Therapeutic Agent	Protection	
	No. of MLD*	No. of Mice
Sulfanilamide	500	120
Sulfadiazine	9,250	280
Serum	28,875	625
Sulfadiazine and Serum	850,000	270
Streptomycin	100,000,000	200

*MLD—Minimum lethal dose.

In two of the five patients with severe forms of the disease, treated with streptomycin alone for four days or longer, the failure of the antibiotic to eradicate the infection was proved to be due to emergence of resistance of their strains. In two large subarachnoid abscesses were found at autopsy; the strains isolated from these were not tested for sensitivity.

The use of streptomycin alone in other severe H. Influenzae infections is too limited to assess its value, but an example of emergence of resistance of strain has already been encountered during treatment of a patient with epiglottitis.

Thus it seems clear that the sulfonamides, rabbit antiserum and streptomycin are all effective agents when used alone under certain circumstances. On the other hand, each has limitations when used alone in the severe infections. An objective basis for comparison of their separate and combined antibacterial effect has been provided by the results of mouse protection tests shown in Table V. Serum alone was not shown to be significantly better than sulfadiazine, the best of the sulfonamides tried; but when the two were used in conjunction, their augmented protective power suggested a synergistic action. Streptomycin alone has never failed in many tests to protect against 1,000,000 minimum lethal doses (M.L.D.) when a single dose, equivalent to 1,000 to 5,000 units per kilogram body weight, was injected intraperitoneally. A single dose as low as 20,000 units per kilogram, either by intramuscular or intraperitoneal route,

has regularly protected against 100,000,000 M.L.D. Preliminary results suggest that the addition of sulfadiazine will enhance this protection; a significant increase in antibacterial effect has been demonstrated *in vitro*.

Conclusions

Streptomycin is the most effective single antibacterial agent against H. influenzae. Since it is bactericidal, its action is rapid and effective against large bacterial populations, both *in vivo* and *in vitro*. Nonetheless, streptomycin, like all other single therapeutic agents, is limited if the infection is of sufficient severity; emergence of resistance of the organisms is clearly the chief cause of failures. Experimental evidence and response in one patient suggest that this defect may be overcome if sulfadiazine is used in conjunction; the two agents have different modes of action and, therefore, organisms resistant to one can be expected to be sensitive to the other. Whether in some patients specific antiserum is needed, in addition, to neutralize the products of H. influenzae which produce irreversible cerebral injury, cannot be answered from the limited experience. However, there is suggestive evidence that the incidence of residual cerebral damage is less when all three therapeutic agents are used together initially, rather than in sequence after a trial of each separately. Additional limitations are imposed by its toxic manifestations. Administration of this antibiotic for weeks in resistant forms of meningitis is to be condemned. Eighth nerve deafness, in some instances apparently permanent, has occurred in a significant number of patients as a result of streptomycin injury, when continued for periods longer than one week. A much higher percentage of patients exhibit vestibular dysfunction. For the present, except in those institutions equipped to study their separate actions, all three antibacterial agents are indicated simultaneously when the meningeal infection is severe, as judged by the criteria described.

MSMS

Little Joe Genius says—

I see that Senator Murray is satisfied with the care given him by the Navy dispensary in Washington. He should be, being as you and I pay for it.

Little Joe Genius says—

I see that Dr. Goin of California had a date with Senator Murray, and proved a tough nut for Murray to crack. Read the record.

Results from the Treatment of Peptic Ulcer

By T. Grier Miller, M.D.
Philadelphia, Pennsylvania

The efficacy of any form of therapy is manifested in the ultimate results that follow its exhibition. In some instances, as in the more acute infections, the relation between the therapeutic procedure and the subsequent course of the disease process may be quite obvious. In other instances one is left in doubt as to the influence of the adopted treatment. This is particularly true when other patients with a similar affection recover in an equally satisfactory fashion without having had any particular medical supervision or after some entirely different type of management.

Peptic ulcer has a notorious tendency to heal naturally. This is proved by the frequency of gastric and duodenal ulcer scars at autopsy in patients who never had ulcer symptoms and so were never treated for such a lesion; also, by the clinical observation that many ulcer patients, when they first consult a physician, give a history indicative of repeated previous attacks of similar nature that subsided without any therapy or change in habits of life. Thus when an ulcer heals under observation and following the adoption of some specific type of therapy, one often wonders if it would not have done equally well without any treatment.

Furthermore, the follow-up data on peptic ulcer cases are always questionable because (1) the lesion has a tendency to alternating periods of activity and quiescence, and the physician often is unduly influenced by the patient's condition at the time of the interview; (2) in most instances the decision as to the degree of activity of the lesion depends on subjective observations by the patient, and the symptoms may be suggestive of a recurrence of activity when only a functional disturbance has occurred; (3) radiological observations,

From the Gastrointestinal Section (Kinsey-Thomas Foundation) of the Medical Clinic, Hospital of the University of Pennsylvania.

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even when obtainable, are sometimes misleading, as when a defect is due to an old ulcer scar or when disturbed function is due to some extra-gastroduodenal lesion, and (4) the patients who have done well are more difficult to follow either by personal interview or letter than those who have persistent or recurrent symptoms. Thus the results of a follow-up study usually are more unfavorable than the actual conditions justify.

In spite of these qualifications on the accuracy and significance of a follow-up study of peptic ulcer, something is gained, at least for the analyst, by a summarization of such data as he can obtain on a large series of personally observed cases. I trust that a review of some of our observations on patients with this disease may also be helpful to others.

Peptic ulcer, like gall-bladder disease, accounts for about one third of the patients who consult the physician for indigestion, and consequently he, like every gastroenterologist, has an opportunity to try out his ideas as to therapy on a large group of cases. In spite of the extensive experience thus acquired by practitioners, no standardized management for simple ulcer and for its complications has as yet been established. I need not refer to the many forms of treatment that have been advocated and that are in current use. Our own, for the simple, uncomplicated case, has not been entirely uniform, but in the main it has been of a very conservative nature. Having established the diagnosis by history and roentgenological examination, we have never felt it necessary to hospitalize the ordinary ulcer patient without at least giving him a trial on an ambulatory basis. On the other hand, when the ulcer has proved refractory to such management or when a complication has been demonstrated, we have promptly hospitalized the case. In the instance of gastric ulcer, we have been more ready to seek hospitalization because of the possibility of malignancy and because of the importance of eliminating such a lesion.

We have believed that the gastric acidity is an important factor in the production and maintenance of ulcer, but have not felt that complete neutralization is necessary for healing, since it would be an unusually phenomenon in nature to require that a normally physiologic state be radically altered in order to bring about recovery from a diseased condition. We have therefore depended largely on food, frequently administered and properly selected, to reduce such acidity as might exist. After all, eating is the natural response to the chief symptom, that of hunger, and doubtless is the basis of the healing that so frequently occurs in the untreated patient. Our routine has been to give six feedings a day and to permit almost any simple bland food, even meats after the first week or two, eliminating only the more acid foods and others that might be mechanically or chemically irritating to the lesion. Feeling that healing is aided by good nutrition, we have insisted upon a high-caloric and well-balanced diet. We have largely avoided alkalis, but in some cases have given a combination of magnesium trisilicate and aluminum hydroxide when food alone did not entirely control the discomfort; this has rarely been necessary in the simple case for more than a few days. Sedatives we have not hesitated to use in the nervous, overwrought person, and commonly we have given some ascorbic acid because of the limitation of raw fruits.

We have given considerable attention to the patient's emotional problems, finding them very common, and in some instances have sought the aid of a psychiatrist. Always we have insisted on such adjustments in domestic and business relationships as were possible, reasonable physical and mental relaxation and a calm, philosophical attitude toward life in general. This, we are convinced, has been most helpful in many cases.

When on such a basis of therapy the patient's discomfort has not promptly subsided, or subsequent radiological examination has revealed evidence of persistent ulcer activity, we have insisted on a short period of complete physical and mental rest, preferably in a hospital. If still, after a reasonable time, no relief has been obtained, or if, in the case of a gastric lesion, the ulcer defect has not decreased in size, we have insisted on surgical interference. For the gastric ulcer case this is especially urgent, because of the possibility that the lesion is malignant; for the refractory ulcer case, whether gastric or duodenal, it is indicated also because of the slight possibility that otherwise he will ever become permanently well. In addition, we have, of course, promptly subjected to operation all patients with a perforation and eventually many with pyloric stenosis or hemorrhage.

With these qualifying remarks, I shall now refer, in the first place, to our results from the medical and the surgical management of the total group that we were able to follow and, secondly, to the results that we have obtained, by a medical pro-

gram, in a subgroup of cases with gastric hemorrhage.

Data from Fifteen-year Experience

During the past few years, various members of my staff have assisted me in an attempt to secure accurate data on the present condition of the 1,433 patients who over the fifteen-year period of 1930 to 1944 have been admitted to our clinic or to my private office because of peptic ulcer. In every instance, the diagnosis was established not only by the history and by physical observations, but also by radiological investigation. In some instances, the patient could not be interviewed and we have had to accept data supplied by him or his physician in response to a questionnaire. When he could not be reached in one of these ways, we have accepted the data recorded on his last visit to the hospital or office and so have placed him in the group having a follow-up only for the years between his original admission and his last visit. Thus, some persons admitted ten or more years ago have been placed only in the one, three or five-year follow-up group.

In the instance of patients operated upon for peptic ulcer, no matter whether previously under our observation or not, we have regarded them as failures on whatever therapy had been instituted before that time and have initiated our follow-up observations with the date of operation. Thus, a patient under observation for ten years, but operated upon after five to seven years, is listed only in our 1+ and 3+ year follow-up group. He is regarded as a failure on his preoperative therapy, but included for information on the results of his operation.

When a patient has died of his ulcer or a complication, without operation, he has been listed as "not improved" by medical therapy; when he has died following operation and before discharge from the hospital, he has been listed as a postoperative death. When he has died later of some cause other than his ulcer or a complication, we have classified him solely on the basis of his subsequent ulcer symptoms, as "asymptomatic," "improved" or "not improved."

In many instances, the so-called "improved" cases are virtual cures, but when they have had any digestive disturbance, even occasionally, that we have thought might have resulted from reactivation of their ulcer or from some complication, we have not put them in this class. It would seem fair, therefore, to regard both the asymptomatic and the improved cases as having obtained highly favorable results. On the other hand, when any evidence, either historical or roentgenological, has indicated the presence of continued or intermittent ulcer activity, we have classified the case as "not improved." Many of these have not been incapacitated individuals or obvious candidates for surgical interference; some have been at their work regularly and have had long intervals of complete freedom from symptoms. Seen at other times, some of them might have been regarded as cured.

It is necessary to say also that perhaps in some instances we have failed to find the patient, especially in the older age groups and in our earlier cases, because he had died, but at the same time we know that some have failed to respond to our request for an interview because they are no longer sick or have moved to some other locality.

Of the total number, 1,074 were treated only medically and 359 surgically. Of the medically treated group, only 59 per cent could be followed, whereas 81 per cent of the patients operated upon were followed for one or more years. Thus, our results in reference to the surgical cases are of greater significance. Furthermore, it must constantly be borne in mind that data such as we are presenting on hospital cases by no means indicate the real incidence of the disease, since many patients recover without any therapy, others as a result of simple treatment, self-administered or under the supervision of the family physician.

In any event, we have secured follow-up data on 923 of the 1,433 cases (64.4 per cent) for one or more years; on 627 of them for three years or more; on 444, for five years or more; and on 166, for ten to fifteen years (Fig. 1). Of the total number, 291 (31.5 per cent) have been subjected to some sort of an operation for their ulcer. These we have regarded as having failed to secure relief on a medical basis, though it is certain that some of them had never been given a fair trial, some had been unco-operative, and some from the beginning had complications that could not be properly managed medically. In addition, there were 122 other patients (19.3 per cent) who did poorly on the medical program that we had instituted, thus, with the patients operated upon, making a total of 44 per cent that may be regarded as having failed to improve on a medical basis.

The ultimate outlook for the 122 unimproved patients still on a medical regimen is uncertain,

but of the 291 patients operated upon 54.6 per cent have been cured and another 23.4 per cent improved. Thus, of the total 923 patients, 78 per cent may now be looked upon as cured or markedly improved.

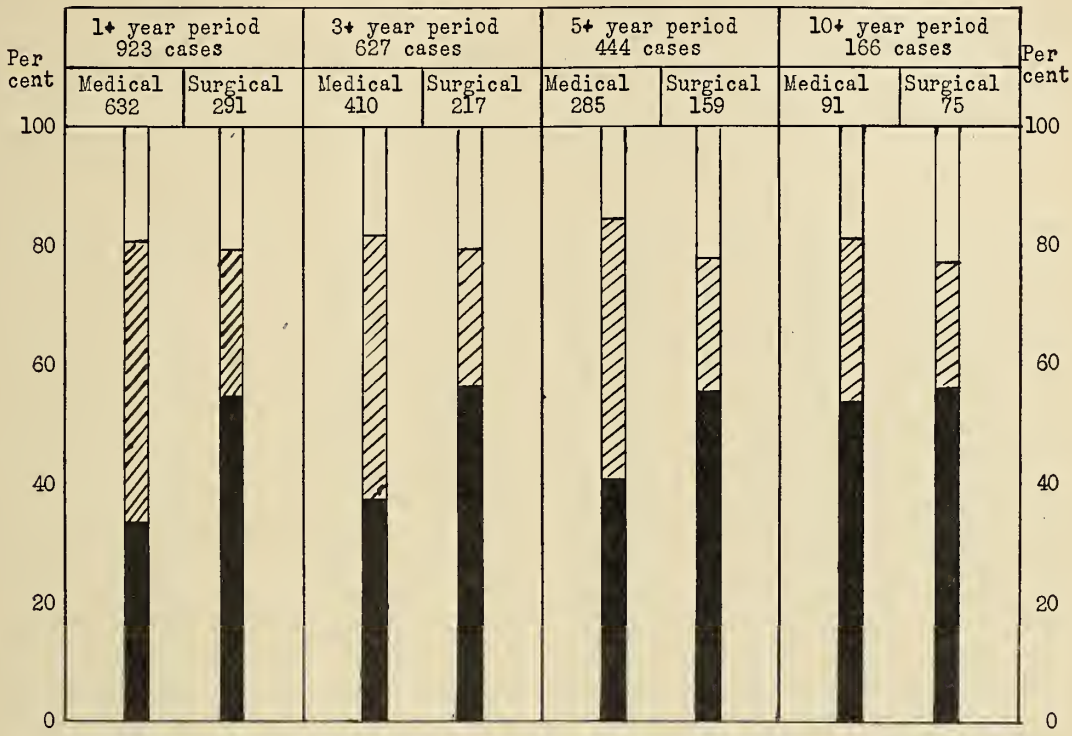

Fig. 1. Follow-up results from medical and surgical therapy in peptic ulcer. Solid portion of each column represents percentage of asymptomatic cases; lined portion, improved cases; open portion, non-improved cases.

Let us similarly analyze the 3+ year group of 627 patients. Of these, 217, most of them having failed to respond satisfactorily to a medical program, came to operation; but of these 217 patients, 79.7 per cent are now asymptomatic or greatly relieved, and of the 410 medical, non-operated-upon cases, 82 per cent are in those favorable groups. Thus, of the 627 patients, after three years, only 18.7 per cent were still, at the time of their last interview, having ulcer symptoms.

It may be said that a longer period of observation would not give such favorable results. Indeed, Heuer,[1] in a review of the literature on the results of surgery in peptic ulcer cases, found that for a one- to five-year follow-up period satisfactory results were obtained from gastric resection in 84.9 per cent; from gastroenterostomy in 77.3 per cent. For a five- to ten-year period, however, he found the corresponding figures to be 79.4 per cent and 50.9 per cent; and for ten or more years, 70 and 61.5 per cent.

Our data do not lend support to such a decrease in satisfactory results with a longer period of observation, either after surgical or medical therapy. Thus, for our group followed five years or more (444 cases), of the 159 operated upon, 78 per cent had satisfactory results, and of the 285 treated medically, 84.6 per cent. Furthermore, for the 166 cases observed over a ten- to fifteen-year period, 77.3 per cent of the surgical cases and 81.4 of the medical ones had good results. For the 166 cases, a favorable result was obtained in approximately 80 per cent.

How can one explain this situation? Do we not constantly see recurrences after years of inactivity? We do, but also we see patients who have had symptoms for several years eventually recover completely. Thus, the two conditions tend to balance one another.

Results from Gastric Resection

We shall at some other time present a detailed analysis of the results from the various types of operation performed in our total series. It is now generally admitted, however, that gastric resec-

TABLE I. RESULTS FROM GASTRIC RESECTION IN 113 CASES OF PEPTIC ULCER

Location of Ulcer	Total Number	Cured (Per Cent)	Improved (Per Cent)	Not Improved (Per Cent)	Died (Per Cent)
Gastric	24	95.8	4.2	0	0
Duodenal	73	79.4	13.7	4.1	2.7
Gastric and Duodenal	10	70.0	0	30.	0
Gastro-jejunal	6	33.3	0	50.	16.6
Total	113	79.5	9.7	7.9	2.7

tion gives the most satisfactory results, and that is our experience. At this time I shall refer only to the cases so treated and only for the period of 1938 to 1945, already reported separately by Miller and Nicholson.[2] During that time, except in special instances, this operation has been the routine procedure of our surgeons for refractory and complicated ulcer. It was accomplished on 113 cases (Table I) that could be followed (twenty-four with a gastric, seventy-three with a duodenal, ten with both a gastric and a duodenal, and six with a gastrojejunal lesion). Of these, three have died—one duodenal case on the fourth postoperative day from peritonitis secondary to preoperative perforation, another duodenal case after twelve months from gastric hemorrhage, and a gastrojejunal case after twenty-one months from hemorrhage incident to a secondary marginal ulcer. Of the twenty-four gastric ulcer cases, 95.8 per cent are now regarded as entirely cured and the others are improved. Of the seventy-three duodenal cases, including the two that died, 79.4 per cent are regarded as entirely well and another 13.7 per cent as improved, thus giving a favorable result in 93.1 per cent. When both a gastric and a duodenal lesion were present, a favorable outcome was less common (70 per cent), and of the six gastrojejunal cases, only two did well. If the gastrojejunal cases are excluded, thus limiting the group to primary resections, a good result was obtained in 92.6 per cent; if, in addition, the one postoperative death is eliminated, the percentage is 93.4.

We have been particularly interested in the twelve unimproved cases (including those that died). We found that six of them had a half or less of the stomach removed, that six did not have the ulcer itself removed, that five had had previous gastric surgery, and that four were highly psychoneurotic, two of them being alcoholic and un-co-operative. These, we believe, are unfavorable factors that deserve serious consideration when any operative procedure on the stomach is contemplated. Often the operation must be done anyway, but under such circumstances it must always be appreciated that the prognosis is very guarded.

Gastric Hemorrhage

Finally, I wish to refer to our results from gastric hemorrhage, which is the outstanding complication that requires medical therapy. Since 1938, we have treated all such cases by prompt and frequent feeding, even in the midst of the bleeding. In 1941, Nicholson and I[3] made a report on our first thirty-two cases so managed; in 1943, Rasberry and I,[4] on an additional forty-three, and now our series has risen to 125. We have not put these patients on a full diet, including ground meats, as originally outlined by Meuhlengracht, but we have included from the beginning, milk, eggs, cereals, gelatin preparations, pureed vegetables and cooked fruits. Often, a few days later, after the cessation of the hemorrhage we have added meats. Only rarely have we used any alkalis and never opiates, but we have used sedatives, such as the barbiturates, rather freely. Fluids by mouth have not been restricted, and transfusions have been given as demanded by the degree of anemia.

The severity of the hemorrhage in our cases has varied, but in the majority the hemoglobin was reduced to less than 50 per cent, frequently to from 20 to 30 per cent. All bleeding cases admitted, even those almost moribund, have been included in the series. In most of the cases the bleeding stopped promptly and it was possible then to secure satisfactory roentgenological study before deciding about subsequent therapy. Ordinarily no surgical interference was permitted until a week or more had elapsed after the cessation of bleeding. In three instances, however, while still uncertain as to whether or not the bleeding had stopped, we advised surgery. In two of these it was found at operation that, as a matter of fact, the ulcer had ceased to bleed, no blood being found in the stomach or small intestine.

These cases are of particular interest. One patient, a man of forty-seven, a high-strung, extraverted salesman, came to our clinic with epigastric pain of such severity that at first perforation was suspected. After a week he vomited blood, and within a few more days, in spite of transfusions, his hemoglobin got down to 22 per cent. All this

time we were feeding him, and, because he was highly emotional, we were giving him rather large doses of sodium luminal. Finally he became stuporous, and nourishment had to be given by tube. The stupor at first was thought to be due to cerebral anoxia. Nystagmus, however, was noted by one of our psychiatrists, who suggested on that basis that his mental condition might be a phenobarbital reaction. Amytal was substituted and the amount of sedation reduced. His mind cleared, and again he took his feedings by mouth, but he continued to bleed. After about two weeks, when the bleeding seemed to have ceased, we were about to have him operated upon, but again he vomited clots of blood. A week later, however, though he was still passing tarry stools, one of our surgeons found no blood in the stomach or duodenum, but did discover a deeply penetrating posterior-wall duodenal ulcer that obviously was healing. He was able to do a gastric resection. The patient left the hospital after another two weeks, quite well.

Another patient, seen quite early in our experience with the Meuhlengracht regimen, continued to have bloody stools for a week and then was operated upon. His ulcer also had stopped bleeding, and we could easily and with greater safety have waited longer for the operation. He also, however, made a prompt recovery.

A third patient was operated upon while still bleeding because he was an older man, had a gastric lesion, and we feared that it was malignant and would never respond to a medical program. As a matter of fact, he had only a benign ulcer, but he died on the operating table.

These cases lead us to the opinion that one should not become discouraged with the prompt and frequent feeding program because the bleeding does not stop at once. If one will only give sufficient blood to prevent severe anemia and at the same time maintain the nutrition, he can in the usual case wait indefinitely before resorting to surgical interference. To do so greatly reduces the hazard of operation.

Of our 125 cases, five have died but only one from exsanguination (Table II). The death that followed operation cannot be attributed to the medical program and might have been prevented had we not abandoned the more conservative regimen. One patient was moribund on admission and received no feedings, one died of coronary occlusion, and one of a perforated ulcer. Thus we have had a gross mortality of 4 per cent, but a net mortality of less than 1 per cent. Even the gross mortality is less than a half of that which Elsom and I found reported for almost 6,000 cases treated by the older starvation and immobilization regimen.

TABLE II. DATA ON PERSONALLY OBSERVED CASES OF BLEEDING PEPTIC ULCER TREATED BY PROMPT AND FREQUENT FEEDING

Cases Reported	Number of Cases		Deaths			
			Number		Per Cent	
	Gross	Net	Gross	Net	Gross	Net
1-32, Reported 1941	32	31	1	0	3.1	0
33-75, Reported 1943	43	41	3	1	7.	2.4
76-100, Reported 1944	25	25	0	0	0	0
101-125, This report	25	24	1	0	4.	0
Total series	125	121	5	1	4.	.8

Summary

Thus, I have outlined very briefly our results from the medical and surgical management of peptic ulcer. It is not only a common but a serious disease, as indicated by the fact that only 56 per cent of the cases we could follow for one to fifteen years were cured or definitely improved on medical therapy. Fortunately, however, with the help of surgery, four out of every five have been relieved. Furthermore, of the cases submitted to gastric resection, the most approved surgical procedure, more than nine out of ten are cured or greatly relieved. At the same time, operation is indicated only in those cases refractory to a medical program, in those with perforation or permanent organic stenosis of the pylorus, in those gastric cases in which malignancy is regarded as a possibility, and in certain cases after hemorrhage has occurred. In only the rarest instance, however, in my opinion, is operation justified in the midst of hemorrhage unless it is complicated by perforation.

References

1. Heuer, G. J.: The Treatment of Peptic Ulcer. Philadelphia: J. B. Lippincott Company, 1944.
2. Miller, T. G., and Nicholson, J. T. L.: Results from subtotal gastric resection in peptic ulcer: the internist's viewpoint. Am. J. Med., 1:476, 1946.
3. Nicholson, J. T. L., and Miller, T. G.: The prompt-feeding program for bleeding gastric and duodenal ulcer. Am. J. Digest. Dis., 8:446, 1941.
4. Rasberry, E. A., and Miller, T. G.: The prompt-feeding program for bleeding gastric and duodenal ulcer. Gastroenterology, 1:911, 1943.

MSMS

Little Joe Genius says—

I see where Michigan started something again when the Michigan Health Council was formed. A recent bulletin from the AMA Council on Medical Service says there are nineteen states which have state health councils. Let's finish the job, and carry out Dr. Brunk's idea on the national scope.

Acute Glomerulonephritis

By Francis D. Murphy, M.D.
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While it is not unanimously believed that chronic glomerulonephritis evolves from an unhealed acute attack, this is a widely held opinion. During the past ten years observations made by investigators have revealed a close relationship between the acute phase and the chronic form, and there is sufficient evidence to substantiate the assumption that chronic glomerulonephritis is a remote consequence of acute nephritis which has failed to heal completely. If the classic textbook picture of hematuria, albuminuria, hypertension, and edema is considered essential for diagnosis of acute nephritis, then many milder forms will pass unrecognized; and not until years later, when chronic nephritis has set in, will the true significance of the mild early episodes become apparent. The absence of a history of an acute attack in many cases of chronic nephritis may be explained to some extent by the fact that during the acute phase the classic picture was lacking. A stumbling block in the proper appraisal of acute nephritis has been the limited view taken of the cause and pathogenesis by many observers.

In recent times, the concept of acute nephritis has changed. It has been emphasized that many mild subclinical forms may exist, pass undiagnosed and untreated, and progress insidiously into the chronic stage before it is realized that the kidneys have become irreparably damaged. This concept was confirmed and extended recently by the histological examinations of Bell,[2] who stated that there are innumerable transitions between subclinical glomerulitis and clinical acute nephritis. Fundamentally the same type of reaction occurs in the two forms; the difference exists only in the intensity of the disease. This better understanding of the clinical and histological features of acute nephritis removes one of the main obstacles which has retarded progress in this field.

The Latent Period

Acute glomerulonephritis may follow one of several courses: (1) Patients may die in the acute attack; (2) subacute or chronic nephritis may develop; and (3) complete healing may occur, or slight albuminuria with no foreign elements in the urinary sediment may persist for years. This last-mentioned type of development was pointed out by Addis[1] as an example of healing with defect. Most patients with acute nephritis recover within a period of six weeks. In some cases healing appears to be complete when in reality the inflammation of the kidney has only become less intense, and the patient is dismissed from further observation with the idea that he is well. He may be oblivious of the fact that his kidneys are damaged until years later when evidence of permanent injury appears. It is, therefore, most important to determine whether or not the renal lesion has healed before dismissing a nephritic patient from treatment. After the severity of the acute phase has passed, there is a period of transition during which recovery may occur or the disease may become chronic. Routine tests such as the phenolsulfonphtalein test, analysis of the blood for retaining nitrogen, and determinations of blood pressure may lead one to believe the lesions are healing satisfactorily, but more exhaustive examination may prove this is not the case. If the physician recognizes that healing is incomplete, he may guard the patient more carefully and make greater efforts to treat him, thus avoiding unnecessary chronic nephritis.

The importance of the latent or the transitional period is becoming better established. As has been pointed out, when the acute episode is over, whether it was mild, moderate or severe, there is a variable of two months to two years when some patients appear well; however, careful examination of the urine will show evidence of a residual lesion in the kidney. This latent period is characterized by complete absence of clinical evidence of nephritis, by albuminuria, and by an excessive number of red and white blood cells and granular casts in the urine. During this most important phase of the disease, the patient's ultimate fate is determined. Lack of proper consideration of this period is responsible for some of the conflicting views of acute nephritis. In the period of transi-

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tion the kidney may gradually heal completely or the disease may progress into chronic nephritis. It may be difficult to say when the latent period ends and chronic nephritis begins, since the latent period may merge gradually with the chronic form; but usually after two years of the previous disease it may be classed as a chronic nephritis.

Not until recently have methods been devised to determine the presence of a minimal unhealed lesion in the kidney. Before the method of Addis was employed and prior to the use of such tests as the sedimentation rate of the erythrocytes and blood urea clearance, the presence of a latent nephritis was largely overlooked. In the latent or transitional period, when the patient appears normal and apparently cured, the key to the correlation between acute and chronic nephritis is found. In the last ten years, the number of after-studies of patients with acute nephritis has grown steadily. These observations are responsible for the modern concept of acute nephritis: Not all classical symptoms of hematuria, edema, hypertension, and albuminuria are required to make a diagnosis of acute nephritis. Milder forms are being recognized and treated adequately in an increasing number of cases. Simple methods have been devised which aid greatly in determining whether renal lesions have healed or remain active after the acute phase is supposedly over.

Prognosis

In reports dealing with the ultimate prognosis of acute nephritis, great divergence of opinion is shown. Some authors have reported that complete recovery is the usual course, with chronic glomerulonephritis following only rarely, while others have expressed the belief that chronic glomerulonephritis is a fairly common consequence found in later years. How statistics may vary in this regard is shown by Snoke[10] in a follow-up study comparing prognosis in a series of cases at Stanford University School of Medicine with that in a series at the University of Rochester School of Medicine and Dentistry.

My own interest in this phase of acute nephritis was responsible for an analysis of over 200 patients with acute nephritis studied in the initial stages at the Milwaukee County Hospital.[8] These patients were kept under observation from two to fifteen years after the onset of the acute phase. The series included both adults and children who were studied in the hospital for three months to a year and who were observed at fairly regular intervals at an outpatient department during the years following. In this series, 25 per cent of our patients became chronic and 12.6 per cent died in the acute phase or soon after. Seventeen per cent, although clinically cured at the time of discharge, did not return for re-examination, and we assumed their recovery was permanent. Of the patients who died in the acute stage and those whose disease became chronic within a year, as well as those who did not return for re-examination, there were eighty-nine whose follow-up study was the chief topic of a paper formerly written;[7] 34.1 per cent recovered and remained healed on re-examination; 9.2 per cent were found to be latent on re-examination.

Rigid adherence to rules of treatments in this period may accelerate complete recovery while laxity may retard healing. It is difficult to determine whether the renal lesion is healing or is becoming chronic. The tests of renal function usually employed are insufficient for this purpose. Determination of the degree of activity of the lesion in the kidney is essential, and repeated examinations are necessary to observe whether healing or inflammation is assuming the ascendancy. Several methods have been used to obtain this information, and we believe that a combination of the results of these tests forms a better prognostic guide than the results of any one test taken alone. To learn which course the disease is taking in a given case requires more than a single examination. We employ the following methods in most of our cases, and while not all of the tests are of uniform importance, we believe that all are good prognostic guides.

Prognosis of acute glomerulonephritis is determined by a combination of clinical and laboratory examinations:

1. From the clinical standpoint, the blood pressure is probably the most important symptom for a prognosis. If hypertension exists, the prognosis is bad; if there is no hypertension, the prognosis may be unfavorable, but the chances of improvement and of complete cure are much better.

2. A study of the urinary sediment, degree of anemia, amount of plasma, protein, and the dilution concentration tests of Volhard is of considerable value, and the blood urea clearance test and the sedimentation rate of the erythrocytes are of particular help. The count of casts and cells in the urinary sediment by Addis' method is considered the greatest aid of all. This test, if done

at regular intervals, gives one a fairly good idea concerning the nature of the disorder.

3. A study of the ability to concentrate urine (Volhard's method) is quite reliable. Progressive impairment of concentration points to a progressive unhealed lesion. Doctor Van Slyke told me this is the most delicate test of all for prognostic purposes.

4. Urea clearance test is very helpful. When the urea clearance is low early and improved later in the course of the disease, the outlook for the patient is good, but when repeated examinations show a tendency towards a drop in percentage, the outlook is unfavorable.

5. While not a basis for determining exactly the progress of the renal lesion, the failure of anemias to respond satisfactorily to usual therapeutic measures, such as the administration of vitamins, iron, et cetera, indicates that the renal lesion is probably becoming worse.

6. Estimations of plasma protein are important prognostic aids, even though the plasma albumin does not drop to the critical level of 2 grams per 100 c.c. of blood. A lowered plasma albumin content, e.g., 3 grams per 100 c.c., and a value for the total protein of less than 5 grams per 100 c.c. are unfavorable indications.

7. Finally, determination of the erythrocyte sedimentation rate is a valuable aid in prognosis. While it is not always accurate as a prognostic measuring stick, it nearly always is. We have employed this test for over twenty years, and we believe a rapid sedimentation rate indicates unhealed lesions becoming progressive. A slowing down of the rate indicates a subsidence of inflammation, while a normal rate points to a healed or almost completely healed kidney.

Treatment

It must be recognized that in acute glomerulonephritis there is a generalized vascular involvement which leads to a vasoconstriction of the kidneys and of the other essential organs of the body as well. The treatment of acute nephritis must be constructed to embrace the entire body, not only the kidneys. The hypertension which follows upon the generalized vasomotor constriction may lead to a complete anuria, to an involvement of the brain followed by convulsions, and to dilatation and failure of the heart caused by increased peripheral resistance. Certain specific measures are recommended for the acute phase of nephritis. Digitalization is necessary because of the ever-present danger of heart failure. The use of 3 grams of magnesium sulphate dissolved in 150 c.c. of 5 per cent glucose solution may be given intravenously once or twice a day until the blood pressure is under adequate control. By this means of controlling the blood pressure, heart failure and convulsive uremia may be forestalled. Calcium gluconate, 2 grams in 50 c.c. of 5 per cent glucose, or two 10 c.c.-ampules, may be used as an antidote for the respiratory embarrassment that may follow the use of magnesium sulphate.

Treatment of acute nephritis has become fairly well standardized. Rest is valuable for the patient, particularly to promote healing of the kidney lesions, and is the first principle in the treatment of nephritis. We have compared, in the past, treatment of patients after the acute phase is over, by enforcing rest for one group and allowing another group free activity. Our results, especially in adults, emphasized the importance of keeping the patients in bed for several months after the clinical features have passed, and until the last remnants of the kidney inflammation have disappeared. Patients who were cured remained at rest until well, and patients who left the hospital before being cured fared less well eventually. Granted that prolonged enforced rest may be difficult in some cases, particularly in younger patients, it is unfortunate that the parents and even the medical advisor often fail to recognize the need of this enforced rest. As for modified bed rest for three or four months, we believe that if rigid adherence to inactivity has failed to accomplish its purpose, then chronic nephritis has probably already set in, and such rigid restriction and rest are no longer absolutely necessary. Physical inactivity serves to obtain rest for circulation in the kidney, which lessens the demand for work upon the kidney.

In addition to enforced physical inactivity, rest for the kidney may be obtained by regulation of the diet. This must not be taken to mean that the diet should be inadequate. The diet of the patient with acute nephritis may be analyzed according to proportions of protein, salt and fluid. Too much protein in the diet keeps the inflammation of the kidneys active. This may be learned from clinical experience, but particularly from experimental work of Addis,[1] Farr and Smadell[4] and Chanutin and Ferris.[3] They have noted that injured kidneys heal faster on a low-protein diet and

slower on a high-protein diet. However, other investigators have expressed the belief that high-protein diet is not injurious to patients with acute nephritis. Keutmann and McGann[5] found a high-protein diet did not retard healing, and return of renal function was accelerated. Many others have accepted a similar opinion. One must be guided by personal experience with patients to arrive at a proper conclusion. It is my idea that a diet containing 0.75 to 1 gram of protein per kilogram of body weight represents the optimal diet for the nephritic, since it fulfills protein requirements adequately and yet does not retard healing of the kidney. My associates and I[6] compared a high acid-ash diet and a high alkaline-ash diet in a series of cases of acute nephritis, and found that as far as healing in the early stages is concerned there appears to be little or no difference. In cases of latent nephritis, in which treatment is continued over longer periods of time, the results are about the same as those mentioned above.

When uremia is impending and fluids must be given parenterally, the kind and quantity to be used are not easy to determine. The rational procedure is based on a consideration of chemical and physiological disturbances and on the correction of them by administration of fluids. The following determinations are made: (1) The sodium and chloride levels of the blood must be known. In some cases these levels are low, requiring the administration of sodium and chloride; in others, they are elevated, calling for restriction of sodium and chloride. (2) The carbon dioxide combining-power of the blood must be known. Usually an acidosis is present, but sometimes alkalosis is found, and appropriate treatment must be given. (3) The albumin-globulin ratio of the blood must be determined. When hypoproteinemia is present, it is corrected by giving protein intravenously or orally. Knowledge obtained from these determinations is indispensable in the successful treatment of the nephritis. In most cases, the proper use of 5 and 10 per cent glucose solution, sodium chloride solution, plasma, and solutions of albumin, sodium bicarbonate, and lactate, will accomplish all that is possible. Diminution in the output of urine, which leads to retention of nitrogenous substances in the tissues and blood, is the commonest defect, and it may be corrected by intravenous administration of 1,000 c.c. of 5 or 10 per cent glucose solution. This may be repeated two or three times a day, depending upon individual requirements.

In nephritis, before uremia sets in, there may be difficulty in excreting sodium chloride. Then, later, when uremia develops, there may be hypochloremia, which, if uncorrected by the judicious use of sodium chloride, may in itself cause added kidney damage. Therefore, in some instances, a solution containing both glucose and saline is administered, and in others, glucose alone. If there is an excessive loss of sodium chloride in a patient with uremia, especially if vomiting precedes coma, it is wise to give 1,000 c.c. of 5 per cent glucose in isotonic saline.

The value of sulfanilamide in the treatment of acute glomerulonephritis has not been particularly spectacular. According to Rappoport, Rubin and Waltz,[9] sulfanilamide has no demonstrable bad effects on renal function; it does not cause an unusual incidence of toxic phenomena in these patients. They conclude that it appears to be without influence on the course and duration of acute glomerulonephritis. They say, however, that the sulfanilamide may be beneficial in the treatment of infection in the patient with acute nephritis. This is true, as experience has shown that the causal infection may be a streptococcal sore throat, which responds to the sulfanilamide.

The place of penicillin in the treatment of acute nephritis is about the same as that of sulfonilamide. The beneficial effects, if any, come from the action of the penicillin upon the primary site of the infection which caused the nephritis.

Bibliography

1. Addis, T.: Osmotic work of kidney and treatment of glomerulonephritis. Tn. A. Am. Physicians, 55:223, 1940.
2. Bell, E. T.: Early stages of glomerulonephritis. Am. J. Path., 12:801, (Nov.) 1936.
3. Chanutin, A., and Ferris, E. B., Jr.: Experimental renal insufficiency produced by partial nephrectomy: I. Control diet. Arch. Int. Med., 49:767, (May) 1932.
4. Farr, L. E., and Smadel, J. E.: Influence of diet on the course of nephrotoxic nephritis in rats. Proc. Soc. Exper. Biol. & Med., 36:472, (May) 1937.
5. Keutmann, E. H., and McCann, W. S.: Dietary protein in hemorrhagic Bright's disease: I. Effects upon the course of the disease, with special reference to hematuria and renal function. J. Clin. Investigation, 11:973, (Sept.) 1932.
6. Murphy, F. D., and Peters, B. J.: The effect of acid-ash and alkaline-ash diets in the treatment of acute glomerulonephritis in children. Am. J. M. Sc., 211:307, (Mar.) 1940.
7. Murphy, F. D., and Peters, B. J.: Treatment of acute nephritis, immediate results and outcome ten years later in 89 cases. J.A.M.A., 118:183, (Jan. 17) 1942.
8. Murphy, F. D., and Rastetter, J. W.: Acute glomerulonephritis with special reference to the course and prognosis: A study of 150 cases. J.A.M.A., 11:668, (Aug. 20) 1938.
9. Rappoport, M.; Rubin, M. I., and Waltz, A. D.: The influence of sulfanilamide therapy upon the course of acute glomerulonephritis in children. Am. J. M. Sc., 211:307, (Mar.) 1946.
10. Snoke, A. W.: Prognosis in glomerulonephritis in childhood. Am. J. Dis. Child., 57:1373, (June) 1939.

Dermatitis Medicamentosa

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Eruptions due to drugs have always been a prolific source of error in dermatologic diagnosis; and the introduction in recent years of many new drugs, particularly of the synthetic variety, has led to an increased incidence of these dermatoses, and has likewise produced new types to extend an already polymorphic clinical group, running the gamut from simple erythema to gangrene. The dermatologist has long been aware of the importance of these eruptions, but it is only in recent years, particularly since the introduction of the sulfonamides, that the interest of practitioners in other fields has been notably aroused.

Various classifications of drug eruptions have been offered, and the following list serves to emphasize the diversity of cutaneous eruptions which may result from the ingestion of drugs.

1. Eczematous
2. Urticarial
3. Erythematous
4. Vesicular and bullous
5. Erythema multiforme-like
6. Erythema nodosum-like
7. Lichen planus-like
8. Pityriasis rosea-like
9. Urticarial and angio-neurotic
10. Varicelliform and varioliform
11. Acneform
12. Ulcerative and vegetative
13. Purpuric
14. Fixed eruptions
15. Dermatitis exfoliativa
16. Pigmentations
17. Herpes zoster and herpes simplex
18. Stomatitis

It should be stressed that most of these manifestations simulate one or another of the recognized dermatological entities, and that the physician must, therefore, have the thought of drug eruptions ever in mind even when some other diagnosis of the outbreak is apparently acceptable. Most often, the eruptions resemble various types of toxic eruptions, being apparent as simple or polymorphous erythemas and urticarias.

In spite of the similarity of drug eruptions to other well recognized dermatoses, there are certain fundamental differences which, while not necessarily distinctive, may serve to point to a medicinal origin for many of these manifestations. Drug eruptions usually develop suddenly in a more or less generalized and symmetrical fashion. They usually have a more striking appearance than the eruption simulated, due to their bright color. In an acneform eruption due to iodides, for example, the base of the lesion is of a brighter red color than is the case with the usual acne lesion, while the pustular tip of the lesion is also whiter and better defined. As a rule, drug eruptions subside rather rapidly upon withdrawal of the drug, notable exceptions being those manifestations resulting from the use of iodides, bromides and arsenic. While itching is usually present, the constitutional symptoms are apt to be strikingly minimal in comparison with the extensiveness of the eruption. Involvement of the mucous membranes occurs rather commonly in these conditions, and lesions of these tissues should excite suspicion.

In some instances, the clinical picture may point toward a particular drug or group of drugs as the guilty agent, but, in general, the specific drug cannot be identified from the appearance of the eruption. Different drugs may produce the same type of eruption in the same or in different individuals, or a single drug may give rise to many dissimilar pictures in different individuals. Certain of the specialized types of eruption, such as the lichen planus-like, the pityriasis rosea-like, and the fixed variety, are due to a limited number of drugs in most instances, while the pustular, nodular and vegetative forms produced by iodides and bromides are characteristic. In such instances, the dermatologist can usually, upon clinical grounds alone, suggest the probable causative drug.

Although subject to great variations in their incubation period, these eruptions usually appear soon after the use of the drug has begun, in from a few hours to a few days. The interval between the institution of treatment with a drug and the development of dermatitis medicamentosa is usually longer with the first attack than in succeeding

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outbreaks. This is due to the fact that most of these eruptions are allergic in nature and the incubation period is longer in the first attack. A notable exception to the usual early onset is met with in the case of eruptions due to bromides, for here the lesions may develop only following prolonged use of the drug and, in some instances, do not appear until some time after ingestion of the drug has been stopped.

It is surprisingly difficult to obtain a history of the ingestion of drugs in many instances, and specific and often repeated questioning is required. Many a patient will give a negative reply when asked if he take drugs of any type, only to state, in response to detailed questioning, that he takes some preparation for headache, constipation, as a "nerve medicine," as a sedative or "sleeping medicine," or as a "blood purifier" or tonic. Two instances might be cited to illustrate the need of persistence here. I saw one woman with a severe pustular acne of the face, this having developed at an age long past the usual time for acne of this type. Asked about the ingestion iodides or bromides, she strongly maintained that she took nothing but a lithia tablet occasionally. She eventually recovered after a series of treatments, only to return with a similar outbreak some two years later. Again asked about the ingestion of drugs, she readily admitted taking bromides, and stated that she had taken them off and on for some years. When reminded of her previous denial of the ingestion of bromides, she stated that she had at that time thought that they were lithia tablets because they "fizzed" when put in water.

In another instance, I was consulted by a physician who gave a history of having had repeated attacks of a bullous and erosive disorder affecting the external genitalia and buccal mucous membranes. The picture suggested the use of phenolphthalein or a synthetic sedative as a cause, but he repeatedly denied the use of any type of drug and was apparently averse to accepting the diagnosis suggested. Just as he was about to leave the office he stated again that he never took any medicines, but at this time added, "except these," as he drew from his pocket a physician's sample of a commercial laxative containing phenolphthalein.

Patients are also prone to fail to mention a drug which they have taken for some time, since they feel that this gives assurance that it could not cause trouble. There are, however, wide variations in the time required for the development of drug sensitivity by different individuals, and in some instances several years may be required. Reactions rarely take place the first time a drug is ingested, but once the sensitivity has been acquired, the outbreaks take place from within a few minutes to twenty-four hours.

In spite of the fact that the vast majority of drug eruptions are transient and have no serious or lasting effects, they cannot always be regarded as only an inconvenience. Not infrequently they lead to prolonged incapacity and to severe illness, and occasionally a fatal outcome ensues, the latter especially if the nature of the cutaneous involvement is not recognized early and the use of the offending agent is continued.

Just as it is possible for drug eruptions to simulate various outher dermatoses, so sytemic reactions to drug intoxication may resemble other systemic disorders. The presence of the cutaneous reaction to a drug may serve as a clue to the determination of the medicinal origin of jaundice, blood dyscrasias, or other systemic manifestations which not infrequently are of serious import.

Since every text on dermatology lists the drugs which give rise to intoxications, and the clinical pictures which they produce, it is unnecessary to include such a list here, but there are certain types of drug eruptions which have a special interest at this time, and which may be discussed.

First of these is the "fixed" eruption, so called not because the lesions persist indefinitely, but because in recurrent outbreaks the manifestations appear each time in the same sites. These lesions are variable in type. They are usually erythematous but may become vesicular. While undergoing involution, the patches often present a polychromatic appearance and may leave a simple pigmentation which becomes intensified with succeeding attacks. Other "fixed" manifestations are urticarial or eczematous in type. The drugs most frequently giving rise to this special type of reaction are phenolphthalein, antipyrine, arsphenamine, aminopyrine and the barbiturates, but cases have been recognized as being due to acetanilid, acetylsalic acid, acriflavine, aminopyrine, antimony and potassium tartrate, bismuth salts, cincophen, oil of eucalyptus, iodides, ipomea, isacen, magnesium hydroxide, mercury, quinine, salicylates, the sulfonamides and veroman. As Abramovitz has pointed out, the same type of reaction may be caused by other agents, such as alcoholic liquors, Karaya gum, certain foods, physical exertion, psychic stress, auto-

toxic substances and menstrual disturbances. In some instances, recurrences may be produced in an affected individual by more than one member of the above list.

The most common cause of fixed eruptions is phenolphthalein. It must be remembered in history taking that this drug is frequently found in pink tooth pastes, mouth washes, cake frostings, et cetera, and even in the small amounts present in such substances, may account for these outbreaks. With all drug eruptions, the size of the dose is not necessarily an important factor, since not unoccasionally eruptions result from the ingestion of infinitesimal amounts of the offending medication. Testing with the suspected drug cannot be relied upon completely, because the patient does not necessarily respond to each ingestion of the causative agent.

As an example of the less common urticarial form of fixed eruption, I can cite the case of a patient with syphilis who developed a few scattered urticarial lesions after each injection of neoarsphenamine. The lesions began to appear approximately ten minutes after the treatment, and the patient could predict not only the sites at which the lesions would appear, but also the order of appearance. I watched him through a number of these reactions, and the sequence was invariably the same.

A more recent cutaneous picture, generally regarded as being at least partly medicinal in origin, was a development of the recent war. This condition, generally referred to as a lichen planus-like eruption, was largely concentrated in the New Guinea area, but occurred with lesser frequency in some other areas, including India and the Mediterranean theater. The eruption, as a rule, began only after atabrine had been taken for some weeks or months. The skin changes have been very variable, and in most instances the initial eruption has been an extensive erythematous, exudative and scaling dermatitis, often leading to the development of a generalized exfoliative dermatitis. The lichen planus-like papules may be present from the outset, or may appear only after the eczematous manifestations have been present for a variable time. Other manifestations met with are those of the mucous membranes, resembling leukoplakia or lichen planus; those of the scalp, where the ensuing atrophy and alopecia may simulate lupus erythematosus; and skin changes suggestive of those seen in poikiloderma and in "fixed" eruptions.

There has been considerable discussion as to the importance of quinacrine hydrochloride in the production of these varied clinical pictures, but nearly all observers agree that the ingestion of the drug is a necessary factor. The rapid improvement which has usually appeared following cessation of ingestion of atabrine, and the common recurrence of manifestations, as focal flare-ups in affected individuals, following the resumption of use of the drug, have been generally accepted as indicating that atabrine is at least the most important, if not the sole, causative agent.

Due to the relative concentration in one geographic area, some writers have emphasized the etiologic influence of other theoretical factors, such as climate, emotional strain and dietary deficiencies. Caro and I, however, presented before the Chicago Dermatological Society, a man and his wife, who had not been out of the United States, and both of whom had taken atabrine for malaria, and they showed the typical lichen planus-like phase of this disorder. At that time, atabrine dermatitis was not known to us, and it was only at a later date that it was appreciated that their eruptions belonged in this group.

As mentioned earlier, the introduction of the sulfonamide group has focused attention upon drug eruptions, first, because of the relative frequency with which cutaneous reactions to these drugs occur, and, secondly, because of the severe systemic reactions, including fever and the blood dyscrasias, which may develop in association with the eruptive manifestations. The frequency with which drug eruptions appear during the use of the sulfonamides varies with the particular drug employed, such reactions occurring most often when sulfathiazole is employed, but also frequently with the use of sulfanilamide, and only occasionally with the ingestion of sulfapyridine, sulfadiazine or sulfaguanidine. Following the taking of these drugs, a wide variety of clinical pictures may develop, the most common being of simple toxic erythematous type, either morbilliform or scarlatiniform. Certain of the less common pictures deserve special mention. A varioloform type of eruption has been described as occurring from both sulfanilamide and sulfathiazole. I have seen two such cases, and in each instance the physician, unfamiliar with this type of sulfonamide reaction, had felt that the condition might well be smallpox.

Another clinical type, often seen associated with drug "fever" is the erythema-nodosum-like variety, the lesions usually developing more rapidly and

more extensively than do the lesions of erythema nodosum, and usually being smaller than the lesions of the latter disorder. They likewise may occur in atypical locations (face and neck).

As noted above, fixed eruptions, previously discussed, have been produced by the sulfonamides.

These drugs have less commonly produced clinical pictures resembling other diseases, such as pemphigus vulgaris, pemphigus foliaceus, exfoliative dermatitis, lupus erythematosus acutus disseminatus, angioneurotic edema and erythema multiforme.

There should also be mentioned the photosensitizing action of the drugs in this group, although there is less tendency to emphasize this aspect than was earlier the case, as the common morbilliform and scarlatiniform types occur chiefly on the covered parts. Peterkin noted reactions of the photosensitive type less frequently among the United States troops than among the British in the same area, a finding which may have been due to the fact that sulfadiazine was usually used with the former troops and sulfanilamide with the latter.

The sulfa rashes do not necessarily have any relationship to the amount of drug taken or to the concentration of the drug in the blood. The eruptions may develop within a few hours after the use of the drug or may not appear until after one to two weeks of therapy.

The local use of the sulfa drugs often has a sensitizing effect, and may lead to the development of cutaneous or systemic reactions with the oral exhibition of the drug at a later date. One must, therefore, condemn the indiscriminate use of these drugs, particularly sulfathiazole, for the external treatment of cutaneous disorders which are not due to infections, or for use in banal infections which may be expected to respond to other and older measures, with whose use complications are much less apt to ensue. This is especially true with reference to the treatment of secondarily infected eczematous or eczematoid disorders, for in such cases the local application of sulfathiazole preparations, while often effective against the infectious element, is prone to produce severe local and general cutaneous reactions.

At present, we are much interested in the types of cutaneous reaction to the use of penicillin. At first it was thought that reactions from this agent were few and unimportant. Soon it came to be

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Psychosomatic Study of a Case of Gynecomastia

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Virchow and organicists have taught for more than a century that all disease has a beginning in some pathology of the cells and tissues of the body, but observing physicians have also known that the emotions are a dominant factor in human experience.

All human beings are psychosomatic problems, and the arbitrary division into the "psyche" and "soma" in the study of disease is merely a contemporary medical attitude and not within the patient at all. This fact was recognized by Hippocrates, who advised that it is more important to know "what kind of a person has a disease" than to know "what kind of a disease a person has."

Gynecomastia may be defined as excessive size of the mammary gland or glands in the male which may occur in youth, young adult life, or middle life. It may either be idiopathic in origin or associated with disturbances of the sex glands. There is frequently discomfort or even sticking sensations in the breast. Whereas, in civilian life these individuals are able to make suitable social adaptations, in the military environment these subjects usually become the butt of ridicule. Nearly all patients suffer extreme mental anguish. Since there is little privacy, they are reticent about exposing themselves to other men, become depressed, reserved, retired, shy, timid, and may even transfer their anxiety features to other organs of the body.

Etiology.—The complexity of factors described by the various authorities on this subject, is proof of disagreement as to any single causative factor. Three chief causes are generally advanced. (1) Heredity as a factor is discredited in most instances, but may be responsible for the condition of pseudo-gynecomastia, an enlargement of the breast area by adipose tissue without actual increase in breast tissue. (2) Mechanical stimulation, or irritation, may play an important role in breast hypertrophy. This factor may be responsible for unilateral enlargement. It is probable that repeated minor irritations, such as rough clothing,

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Released for publication by the Surgeon General.

habitual rubbing or pressure over a nipple area may be responsible for unilateral enlargement, i.e., stimulation of the nipple areas in females may produce hypertrophy or even colostrum without the presence of a pregnancy. (3) Hormonal imbalance is responsible for many cases of gynecomastia, and here a maze of endocrine inter-relationships produces a confusing picture. Certain cases of hermaphrodism or pseudohermaphrodism may have been associated with this condition. A few castrated males, or even those with the prostate removed, have developed breast enlargement. Several cases have been recorded in which breast changes accompanied a teratoma of the testicle, or a chorioepithelioma of the testes. Endocrine disturbances of the adrenal cortex, pituitary, and thyroid have all been found associated with cases of gynecomastia. Gynecomastia may be due to increased estrogenic production, or a decrease in the androgen-estrogen ratio. Experimental and clinical studies bear this out in part; however, they do not entirely substantiate it.

Pathology.—With hypertrophy of the breast in the male, there occurs ductal but not acinar proliferation, and an increase of the periductal fibrous tissue. The miscroscopic picture is indistinguishable from fibroadenoma or chronic cystic mastitis of the female.

Treatment.—Treatment may be (1) surgical, (2) endocrine therapy where overt endocrine stigmata are present, or (3) radiotherapy.

Case Report

With the above factors in mind, the following case is presented to illustrate the interweaving of the "psyche" and "somatic" pattern.

This patient was a thirty-four-year-old soldier with thirty-nine months service, overseas eight months, in combat two months with the Ninety-fifth Division in the capacity of an ammunition carrier. He was evacuated because of an anxiety syndrome, incident to his service at the front. A perusal of his past social history revealed the following background. His parents did not get along well together, for his father was an irresponsible man, who spent the greater portion of his earnings in the pursuit of personal pleasures, and did not provide adequately for the family. He abused the patient's mother, whom the patient termed as a "weak woman." His mother, who was sixty years of age, was on a strict diet and "had to get weekly shots." He could not identify his mother's disability. The patient was one of five siblings. One brother had tuberculosis and asthma. Another brother had a serious stomach disorder and other ailments. Two sisters were living and well. There was no history of breast enlargement in the other male members of his family. The patient was seemingly sentimental and emotional in the discussion which included his mother. It was further estimated that he was closer to his mother and liked his sisters better than his father and brothers.

Developmental History.—The patient had the usual childhood diseases. He came to the United States from Russia at the age of twelve years, and entered school at that age. He repeated the second grade, made grades below average, and found arithmetic and spelling difficult. He quit school at the age of eighteen years, after completing the sixth grade. Although he was able to take part and rather liked active sports, he made few friends among the children of his own age group. The patient left his home at the age of twenty-three years because of conflicts with his father. His work history showed a tendency to frequent shifts of employment. He first worked as a peddler, then a laborer. He drove a taxi for sixteen months, but left this employment because he saw "many bad things." He told of explaining to his mother the immoral situations he witnessed while driving a taxi. His mother was horrified and urged him to change jobs before the job "made a bum out of me." Then he worked as a film loader and general helper, earning $40 per week prior to induction.

Military History.—During his basic training he went on sick call frequently and was hospitalized because of gastrointestinal distress. This he attributed to a change of diet from which he was formerly accustomed. The organic workup did not reveal any pathologic condition. At this time he began to develop headaches. He admitted being made miserable by the slurring comments of other soldiers. He stated that he was the subject of disparaging remarks, was frequently laughed at and persecuted. However, he attempted to ignore these situations and make the best adjustment under these trying conditions. During his front line service, his headache became increasingly severe, he vomited more frequently and was then evacuated to the Zone of the Interior, where, he stated, he made a remarkable recovery.

Sex History.—The patient reached puberty about the age of twelve years, and his first nocturnal emission occurred at that age. He masturbated until the age of fifteen years; then because of numerous guilt feelings he ceased this practice. He manifested some interest in girls at the age of seventeen years, but stated he had "no luck" with them because of his breasts. He denied any heterosexual congress as a civilian, and as a soldier he shied away from girls because of the possibility of venereal disease. The army films had a tendency to frighten him away from any contemplated sex ventures He married while on a convalescent furlough to a woman, twenty-four years of age, whom he had known for six years. She was a college graduate. The patient stated that he was very much in love with his wife. However, he believed that his in-laws were trying to break up his marriage, and his immediate concern was to get his

wife located in a home of their own. He further stated that his marriage was complicated by reason of his deformity. His wife was extremely curious about this condition, and he had to undress in private so as not to permit her to see his breasts. He felt that possibly this condition might threaten his marital felicity. Regarding the more intimate phases of his sex life, he went home on week ends and was able to consummate sexual congress to the mutual satisfaction of both parties. He practiced marital continence. He described his sex act as normal, ejaculation as not premature, and there was quantity to the ejaculate.

Physical Inspection.—He was a well-nourished white male presenting enlarged breasts about the size of a lemon and of equal size. The breasts were soft and flabby, and did not contain glandular tissue. The nipples were normal in size, and no secretion was obtained from the nipples on pressure. His penis was definitely small; both testes were present in the sac. The right testis was the size of a pea and the left was about two to three times that size. The general body hair distribution was present on face, arms, axilla, pubes and legs, but was rather sparse on the chest. He had a girdle distribution of fat, citing a recent gain of 30 pounds. He had no blurring of vision, no temperature intolerance, and his appetite was good. He had no craving for carbohydrates, denied excessive water intake and did not urinate excessively.

Laboratory Data.—The glucose tolerance test was within normal limits. However, he spilled sugar at 115 and 90 mg. respectively, showing a lowered renal threshold. X-ray of the skull showed calcification of the falx cerebri, with the sella turcica normal.

Discussion

This patient had gynecomastia as long as he could remember, associated with under-developed sex organs. Gynecomastia may be present as a solitary finding with no concomitant endocrinopathy. It may be of special significance only as an incidental finding. However, in this particular case endocrine stigmata were present. It is postulated that normal development of the genital apparatus proceeded until the age of twelve and also at that time his breasts apparently reached maximum size. From that period on, somatic growth did not occur.

In speculating what may have occurred at this stage of pubescence, two postulates are advanced. (1) Since the action of the testicular hormone is dependent on the gonadotropic factor of the anterior pituitary, there may have been a deficiency in this factor; thus, the genital organs may not have been brought to a full stage of somatic maturity. (2) Perhaps the more tenable explanation is that there may have been an inherent structural defect in the testes, so that the genital organs as receptors could not produce enough male hormone to bring about the growth of the penis, scrotum, prostate, seminal vesicles, epididymus, vas deferens, and the masculine patterns of aggressiveness, vigor and self-confidence.

One can only speculate on the etiologic relationship of gynecomastia on his "pychic life." Aside from this anatomic structural defect, his history revealed the coexistence of the rich ingredients which make for a traumatic neurosis, namely, (1) hereditary constitutional predisposition, (2) situation, and (3) conflicts. No attempt was made to assign precedence to either the endocrine or psychopathologic viewpoint in the causation of his neurosis.

Though treatment was not attempted on this patient, it was felt that surgical intervention (breast plastic operation) plus suggestive psychotherapy would be of benefit in helping this patient resolve some of his difficulties.

Conclusion

Gynecomastia, as an anatomic structural defect, has subjected this patient to actual as well as implied psychic trauma, causing anxiety symptoms of lifelong duration, and a lowering of his social adaptive capacity.

MSMS

NORTHERN TRI-STATE MEDICAL ASSOCIATION

The Northern Tri-State Medical Association will hold its seventy-fourth annual meeting on April 8, 1947, in the Rackham Memorial Educational Building in Detroit. Donald Douglas, M.D., of Detroit is president. Drs. Edward D. Spalding and Wm. Henry Gordon of Detroit are members of the Council.

Morning Session—8:30 A.M.

Registration

Welcome Address—Winfred B. Harm, M.D., President, Wayne County Medical Society

"Recent Advances in Thoracic Surgery"—Wm. M. Tuttle, M.D., O'Brien Chest Clinic, Detroit

"Recent Advances in the Treatment of Diabetes"—J. W. Conn, M.D., Associate Professor of Internal Medicine, University of Michigan

"Recent Developments in the Management of the Menopause"—Sprague H. Gardiner, M.D., Indianapolis, Indiana

"Enigmatic Anemias"—William Magner, M.D., Director, Department of Pathology, St. Michael's Hospital, Toronto, Canada

Luncheon—12:00 M.

Speaker—George F. Lull, M.D., American Medical Association

Afternoon Session—2:00 P.M.

"Surgical Aspects of the Abdominal Wall"—Frederick A. Coller, M.D., University of Michigan

"Medical Genetics and Public Health"—Laurence H. Snyder, M.D., Department of Zoology and Entomology, Ohio State University

"Recent Advances in Cardiology"—Edward D. Spalding, M.D., Detroit

Coloboma of Optic Nerve

By Harold H. Harms, M.D., and
Frank L. Ryerson, M.D., F.A.C.S.
Detroit, Michigan

ALTHOUGH COLOBOMATA OCCUPY a moderate share of the opthalmologic literature, colobomata of the optic nerve, unassociated with large defects of the surrounding choroid, are quite rare. Rarer still are those cases which have fairly useful vision in the affected eye, despite the large defect, although Adler[1] described a case of bilateral partial colobomata of the optic nerve, with almost normal central vision in spite of the large field defects.

Theories of Cause

Since 1821, when the term *coloboma* was suggested by Walther for these congenital anomalies where a portion of the eye is lacking, various theories have been advanced as to the cause of these defects in ocular structure. These theories include[4] intrauterine inflammation, failure of vascular development in the mesoblast surrounding the cup, et cetera, as causes for the defects, but have many associated points difficult of explanation. The factor of heredity is also recognized in colobomata in general, Snell having found clinical evidence of hereditary transmission in five generations. Transmission is specific for one group of defects and follows Mendelian laws, the deformity usually appearing as a dominant characteristic (although Kayanagi in 1921 produced colobomata in inbred rats as a Mendelian recessive).

In general, however, the most widely accepted theory of cause is that of von Ammon, which explains the optic nerve defect as being due to faulty closure of the fetal cleft. This is consistent with the reasoning of Seefelder,[6] who demonstrated that the closure of the ocular cleft began in the middle and advanced distally toward the cup and proximally toward the stalk. He thought that if the cleft failed to close in the proximal portion, then coloboma of the nerve would result.

The cause of this faulty closure of the fetal cleft is in turn debatable, von Hippel[8] having assumed that thickening of the mesoderm prevented union of the layers. However, von Szily[9] and Seefelder[2] found no especial thickening of the mesoderm in rabbit colobomata, and they concluded that either marked proliferation or almost complete retardation of growth of epithelial elements preceded coloboma. This is well borne out by the work of Payne[5] on human embryos, with rapid overgrowth of retinal elements, and inclusion of the retina in the stalk of the optic nerve.

Characteristics

The size of the pseudodisc varies greatly in coloboma of the optic nerve, ranging from normal to as much as twenty times normal, but it is usually[7] two to four times normal. The deep excavation of the disc, often resembling a marked glaucomatous cupping, is more pronounced in the inferior portion, and its color may vary from grayish white to the more frequently seen dull bluish pink, without the mottling characteristics of the lamina cribrosa. The distribution of the vessels, which is the most distinguishing characteristic, is highly variable. According to Caspar,[3] the arrangement of the vessels in coloboma of the optic nerve may be classified in three groups: (1) cases in which all the vessels emerge from the lower portion of the pseudodisc, even those which later turn upward; (2) cases in which all the vessels emerge at or a little above the center, their arrangement being almost normal, and (3) cases in which the vessels emerge at the circumference of the disc, and appear to bend sharply around its edges.

The vision is usually seriously impaired, although it may be normal. Coloboma is usually unilateral, although it may be bilateral. Visual field defects vary from corresponding enlargement of the blindspot to concentric contraction. There may be contraction of the upper portion of the field, or a centrocecal scotoma.

Case Report

A colored housewife, aged fifty-one years, was first seen in the clinic on May 27, 1946, complaining of pain behind her eyes, of three weeks' duration. She stated that her eyes first presented difficulty at the age of thirteen years, when she began to have difficulty with her school work, with an associated supraorbital headache. Spectacles fitted at that time corrected the difficulty, but about once a year since then poor vision had developed, with a sensation of a veil passing before both eyes, which was corrected by a yearly change of spectacles. Her medical history was noncontributory, as was her family history, as neither parent nor any of the other nine children had had a fundus examination.

Examination:

Uncorrected visual acuity, R. V. 20/40; L. V. 20/30
Corrected visual acuity, R. + .62 sph 20/15 —1
L. + .25 sph 20/25 +3
Add: + 1:50 O. U. Jaeger No. 1 at 15 inches.

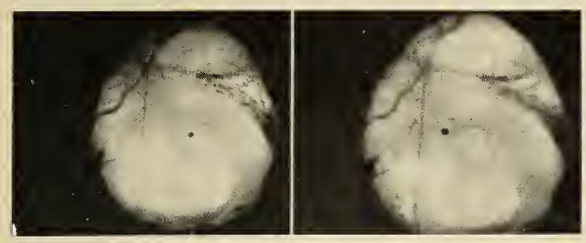

Fig. 1. Photographs of fundus: (*left*) superficial view; (*right*) deep view.

There was no nystagmus, and extraocular movements were normal. Maddox rod and alternate cover test showed no phoria. Lachrymal apparatus was normal. Intraocular tension (Schiotz) was 21 and 19 mm. mercury, right and left, respectively. Media were clear bilaterally, and irides were normal. The right fundus was normal, and the left was normal except for a large depression in the region of the disc, about four times the size of a normal disc, with the vessels bending sharply over the inferior edge. The depth of the excavation was about 12 diopters, and the color of the deepest inferior portion was bluish white. The area above that was bluish pink, with a mottled triangular veil over its temporal portion, resembling the lamina cribrosa. Occupying the superior area and exhibiting no definite excavation was what appeared to be the upper one-third of an optic disc, pinkish in color, with the vessels entering it in a more nearly normal pattern, although they were slightly nasal (Fig. 1.). Even the sharply bending vessels at the inferior portion of the pseudodisc could be traced to this area.

There was no defect of the surrounding retina or of the macula.

Visual fields on June 19, 1946, showed a normal field for the right eye, except for a very slight superior depression. The left eye showed a slight peripheral depression of form fields (Fig. 2) with a 1° test object, most marked superiorly. Projection on a tangent screen at one meter distance showed a much enlarged blindspot (Fig. 2). No separate central scotoma was demonstrable.

Comment

A case has been presented, exhibiting some of the characteristics of typical unilateral coloboma of the optic nerve, with photographs of the defects at various depths. The increase in size of the pseudodisc, the depth of its excavation (especially inferiorly), and the visual field changes with considerable enlargement of the blindspot and some peripheral depression of the field, are quite characteristic. Vision is strikingly good, considering the extent of the defect.

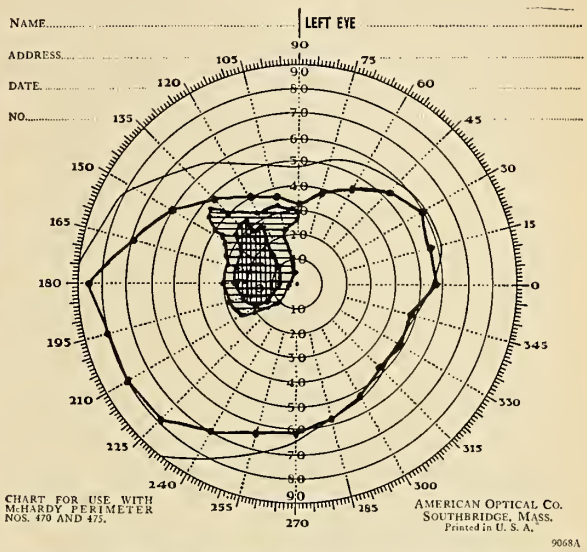

Fig. 2. Visual field of left eye with 1° white test object. Enlargement of left blindspot is shown by crosshatched area for 2° white object on tangent screen, and by horizontal striate area for a 1° white test object.

Bibliography

1. Adler, F. H.: Am. J. Ophth., 20:777-778, (Aug.) 1937.
2. Bach, L., and Seefelder, R.: Atlas der Entwicklungsgeschickte des menschlichen Auges. Leipzig: 1911-1914, Pts. 1, 2, 3.
3. Caspar, J. H. R. L.: Ueber das Coloboma des Sehnerven. Bonn: J. Bach, 1887.
4. Duke-Elder: Textbook of Ophthalmology. Vol. 2, p. 1252, 1938.
5. Payne, B. F.: Tr. Am. Ophth. Soc., 37:458-464, 1939.
6. Seefelder, R.: Arch. Ophth., 90:129, 1915.
7. Steinberg, T.: Am. J. Ophth., 26:846-849, (Aug.) 1943.
8. von Hippel, E.: Die Missbildungen u Angeborenen Fehler des Auges, Inh. 2 Aufl., 2: Kap. IX, 27, 1918.
9. von Szily, A.: Klin. Monatsbl. f. Augenh., 1945. (Suppl.) 201, 1907.

LEHIGH VALLEY PLAN PAYS HOSPITAL BILL OF $1,260.50

Hospital Service Plan of the Lehigh Valley, Allentown, Pa., has just paid a hospital bill of $1,260.50. The Blue Cross patient was Mrs. Barbara Andrews who spent twenty-two days in the Allentown Hospital. The $1,260.-50 hospital bill, the greater part of which was for penicillin, was covered in full except for a $2.00 ambulance charge.

Earlier in the year, $352 was paid Mrs. Andrews for another hospital stay, making a total of more than $1,600 paid her in benefits during 1946.

—*Blue Cross Bulletin, December,* 1946.

All factories should include a chest x-ray as part of the pre-employment examination. As the advantages of an x-ray program become understood, factories may be expected to provide such measures as routine procedure.

Editorial

MENTAL HYGIENE FOR CHILDREN

A PROGAM FOR mental hygiene children's clinics has been developing in Michigan for over a year. So far, such clinics have been largely lay inspired.

During the war about one and a quarter million persons were rejected from the draft on account of mental and emotional conditions. Over half of the hospital beds in the United States are occupied today by mental patients. Medical departments of the armed forces have shown that vast numbers of those in the services who developed disabling emotional conditions or adjustment problems, even to a degree requiring removal from the services, were individuals who had behavior problems or who had been more or less "problem children."

Some type of guidance for parents or school authorities, or for the children themselves, would in many instances have guarded against these failures in the military, and would have salvaged these young people for useful lives. Many of them would not have been taken into the armed forces, for we now know that they should never have been exposed to the stress and strains of military adjustment.

To recognize and to guide the preventive procedures needed to avoid these hazards is primarily and fundamentally a responsibility of the medical profession, and the medical men of the state and nation should be most interested in working out whatever plans and programs are necessary.

Each county medical society, as well as the state medical society, should be ready to do its part. Each society should lose no opportunity to give advice, to help with the provision of whatever facilities are necessary to study these emotional or behavior problems, and to treat them in their incipiency. Child guidance clinics have been established in nine centers in Michigan and are considered in more. The hitch so far has been the so-called impossibility of securing a sufficient number of trained child psychiatrists who are willing to do the work.

Our schools and our courts are discovering mentally unbalanced and delinquent children who need medical or psychiatric care as well as trained supervision and guidance. The state organizations now promoting this program say they are handicapped by lack of trained doctors. We admit the woefully insufficient numbers of well-trained psychiatrists, but we do believe that any physician with proper training could apply his skill to children and youths. IT IS OUR DUTY AND OUR OBLIGATION.

We recognized this problem editorially in the February, 1943, number of THE JOURNAL. There were three editorials on the subject, one quoting the chairman of the State Mental Hygiene Committee, and two by a well-known psychiatrist who wished to remain anonymous. Attention was called to the fact that every error in taking into the service a mentally unfit person was a thirty thousand dollar mistake, and that fifteen thousand such mistakes had occurred in 1942 alone. Everyone of those cases could cost the government that amount for care for a "service connected disability."

Any help the profession can now render will not only be extremely patriotic, but will provide this tremendous group of persons with professionally, medically trained leaders, instead of risking their drifting ultimately into some layman supervised regime. We have a clear-cut opportunity to make another first for Michigan by stepping into the procession and exerting our influence for well-chosen leadership. We have and can supply that leadership.

MEDICAL PROPAGANDA

THE TREND OF REPORTS now is that the fight *was* on for socialized medicine but that it is not *now* active. Articles tell of the fight as if it were a thing of the past.

But it is not forgotten. President Truman in his State-of-the-Nation speech again suggested compulsory health service. Mrs. Roosevelt in her "column" comes back to it in insidious ways. In her opus of December 18, 1946, she accuses the American Medical Association of opposing all medical care programs, such as the nonprofit plans of various states and the Wagner-Murray-Dingell plan, grouping them together. This could only be done in a deliberate piece of propaganda, for she knows full well that the voluntary nonprofit plans

for care, as sponsored by the profession, have no kinship with the socialized medicine plan of Roosevelt-Truman-Wagner-Murray-Dingell-Pepper, et al. To group these two proposals together, and to array the American Medical Association against them, is misleading and vicious misrepresentation of fact, and with the hold she has on the imagination of a great mass of readers she should be superior to such machinations.

But she is a propagandist without qualms. On January 11, 1947, she "Views Canadian Medical Plan." "In Saskatchewan they found it difficult to keep good doctors in their rural areas, so taxed themselves locally in order to give their doctors sufficient income." They have a provincial plan costing the individual five dollars a year, and the family not over thirty. She points out this low rate and adds, "If the revenue from the special tax should prove insufficient, the province will undertake the additional care." This last sentence is the joker, for that does not mean additional taxes to the average reader. The province will provide, but the reader does not question how. This is another underhanded thrust in the way of socialized medicine.

The December 21, 1946, issue of the *Saturday Evening Post* contains an article by Greer Williams that every doctor should read and ponder. There are many timely suggestions and some wiley innuendoes. The charge is made, and authorities quoted, that only half of the profession is worth its salt. The article suggests some ways for the layman to find out which doctors are reliable. The insinuation that half of them are not giving good care, are careless, or unreliable, runs all through the article.

As an individual, and as a student of medical training, medical men, and medical services, the writer wishes to go on record here and now as repudiating this statement, and we are happy to disagree with one very famous medical man named and with a group of others who were mentioned as "medical authorities," *"distinguished physicians,"* who to improve the medical profession would "chloroform half of the profession."

In any mass of men there will be some with less ability and knowledge or training than others, but in medicine, with all the safeguards established, that list is very small. If called upon to make an estimate, if it became necessary to employ one of the physicians in the community which we know and have known intimately for all our professional life, we would not hesitate to place our own care in any one of at least ninety-five per cent of the group.

We deplore the poor estimation of doctors evidenced by this article and the so-called medical authorities. We believe that is very unfavorable propaganda.

There are no groups of men with higher ideals and training, as a whole, and this we thoroughly believe in spite of Greer Williams.

By the way, who is Greer Williams?

Is she "tops" in the field of writing?

As a writer on medical subjects, we feel she should be chloroformed.

HOW TO SELECT A FAMILY PHYSICIAN

ONE'S FIRST THOUGHT is to call the county medical society when wishing to select a family physician. That certainly should be one of the first steps, even though propagandists for social change would have us believe that the county medical society is biased and would give a rubber stamp endorsement of its members. Knowledge of the prospective doctor's success in practice is desirable. Many other methods of selecting a physician are available. Is he on the hospital staff? Is he a member and an attender of the county medical society? What is his standing with the bank? What are his social affiliations? Is he active in civic affairs? Does he have the respect of the clergy? What of his own family life? Is he reasonably busy or overworked? Is he genuinely interested in his profession, or is he greedy? Is he a doctor because he loves it or as a means for a good livelihood?

Such a line of study sounds perverse or useless, but in selecting a doctor for one's family, one is selecting the person who will stand in relation to him and his family in a way that would and should be entrusted to the most reliable and resourceful person to be found. No effort is too great to satisfy this need, and it should not be left to emergency demands. After sufficient study, one should call upon the doctor and then make the decision by first-hand contact. No doctor will resent such contact, and every doctor should feel complimented to be so considered.

In selecting a specialist, the profession has done the job in a workmanship manner by the establishment of fifteen American Specialty Boards, whose certificate is a genuine stamp of approval. Not all specialists have passed these boards, and not

all have the opportunity to do so, but the method of approval is there, and the same advancement for general practitioners is now in process of development. Again, probably a great majority cannot take the time to pass these requirements, but the method is being considered. We also know that some doctors are not in favor of these boards and their work, believing that they are setting too high a standard. These boards are a purely voluntary development, available to those who wish to use them, and not compulsory either to the doctor or the patient. However, for certain examinations the government is demanding such certification.

SPECIAL COMMITTEE ON INFECTIOUS DIARRHEA

At a meeting of the Special Committee on Infectious Diarrhea held January 8, the chairman reviewed the action leading to the formation of this joint committee to deal with this important subject. He pointed out that the presence of obstetricians, pediatricians, and the Director of the State Laboratories on the committee should insure a comprehensive report on this subject.

Attention was called to the frequency of newspaper reports of epidemics here and there about the country and to the fact that no hospital should consider itself immune, merely because it had been fortunate in the past. The relatively mild epidemic occurring in the Saginaw General Hospital in September, 1946, was discussed with particular reference as to how the epidemic was brought under control and the nursery reopened for new cases within a period of one week.

This led to a discussion of the service offered by the State Health Department to institutions and hospitals where the disease may be epidemic. When requested to do so by the Hospital Superintendent, the State Health Department is prepared to send a team to study the situation and to submit a report of their findings together with suggestions. While the availability of such a service is not generally known, it is interesting to note that the team has been utilized in at least seven of the larger cities of the state, as well as having been called to at least two Detroit hospitals.

Dr. W. F. Seeley gave considerable emphasis to the point that the supervision of maternity hospitals and nurseries would never be very efficient until the licensing of such institutions was made the responsibility of the Board of Health, rather than being under Social Welfare. He pointed out that this matter had been given considerable study a few years ago by the Maternal Health Committee, but nothing came of it. Dr. G. D. Cummings volunteered to get Dr. Alexander Campbell's viewpoint and report later. If maternity hospitals could be given a closer tieup with the health agencies at the state level, it would become much easier and simpler to bring about certain preventative procedures and regimens.

Dr. Harold Henderson and Dr. Campbell referred to the advisability of some one or more members of the hospital staff accepting the responsibility of the newborn nursery. In many instances it has seemed that this assignment is best handled by a pediatrician. This is particularly true if a hospital is offering resident training in pediatrics.

In view of the fact that Dr. Cummings has been working on this problem for the past four years, the chairman requested him to submit a first draft outline or paper on the fundamentals of prevention and treatment of epidemic diarrhea of the newborn for the consideration by the committee at its next meeting. Dr. Cummings agreed to do this.

ON THE RUN

In cor pulmonale, where the available arterial oxygen is unusually low and the cardiac output high, digitalis is not only useless but actually dangerous.

• • •

Locally implanted penicillin is of greater value, unit for unit, than injected penicillin in the control of wound infection.

• • •

When the edema of cardiac failure is unmoved by diuresis, suspect accompanying liver cirrhosis.

• • •

Painless hematuria is one of the most frequent signs of early renal tuberculosis.

• • •

The symptoms in mesenteric thrombosis are more acute and demanding when an arterial embolus rather than a venous thrombosis is the primary cause.

• • •

It often takes several hours after the onset of an intra-abdominal surgical emergency for distinctive diagnostic signs to develop.

Selected by W. S. Reveno, M.D.

Proceedings of the Detroit Physiological Society

Session of November 21, 1946

The following topics were discussed, and abstracts are herewith presented.

Vitamins in the Urine of Newborn Infants

Brenton M. Hamil, M.D., Department of Pediatrics, Henry Ford Hospital, and Harold H. Williams, Ph.D., Children's Fund of Michigan, Detroit.

The concentrations of thiamine, riboflavin, niacin, N^1-methylnicotinamide, pantothenic acid, biotin and vitamin C were determined in urine from twenty-four breast-fed infants during the first seven days postpartum. Vitamin C was determined in cord blood and in blood samples from the mothers and infants. The computed average daily intake of each of the vitamins from breast milk was compared with the calculated urinary excretion of each vitamin for each twenty-four-hour period. Both concentrations and daily excretions were relatively high during the first three days, the period of rapid weight loss and low milk intake. The maximal average concentrations of thiamine (13 micrograms per 100 c.c.) and pantothenic acid (213 micrograms per 100 c.c.) were found in the urine excreted on the third day of life; of riboflavin (140 micrograms per 100 c.c.) on the first day; and of nicotinic acid (128 micrograms), N^1-methylnicotinamide chloride (3820 micrograms), and biotin (4 micrograms) on the second day of life. With subsequent rapid weight gains and increasing intakes of vitamins, urinary concentrations and daily excretions diminished. The average daily excretion by the infant was estimated to be in the same range as the total amount in the baby's extracellular fluid.

The vitamin C content of cord blood ranged from 0.66 to 2.18 mg. per 100 c.c. Maternal serum contained 0.04 to 1.19 mg. per 100 c.c. on the first day postpartum, while the infant's blood ranged from 0.20 to 1.72 mg. The changes in blood level of vitamin C varied widely among the individual women and infants during the first week postpartum. In general, concentrations of vitamin C in urine were high during the first two days of life but dropped to low levels by the fourth day.

The data suggests the possibility that the physiologic processes of intrauterine development require greater saturation of the tissues with these vitamins than is necessary in the gaseous environment of extrauterine life; or, that they accumulate in fetal tissues in varying amounts depending upon changes in *p*H, oxygen tension and physical factors, alteration of which at birth causes their excretion.

Inactivation of Prothrombin with Fibrinolysin

Walter H. Seegers, Department of Physiology, Wayne University College of Medicine, Detroit.

Fibrinolysin is prepared from bovine plasma. It is capable of decomposing fibrinogen so that the latter can no longer be clotted with thrombin. It will also decompose a fibrin clot. It is unable to do this in ordinary plasma because the fibrinolysin is found therein in an inactive form, and during the isolation procedure it is activated in the laboratory. In this form, active concentrates have recently been prepared and furnished to us (Eugene C. Loomis, Parke, Davis and Company) as dry amorphous saline soluble material.

We discovered that this fibrinolysin preparation will destroy purified prothrombin very rapidly. Much depends, however, upon the relative quantities of fibrinolysin and prothrombin used in the experiments. If large quantities of prothrombin are mixed with a small amount of fibrinolysin, equilibrium conditions are reached and appreciable quantities of prothrombin remain in solution. Extensive study of such conditions show that the inactivation does not follow stochiometric proportions or any of the classical enzyme reactions.

In order to demonstrate the inactivation of prothrombin by fibrinolysin, it is necessary to have purified materials because there is a powerful inhibitor present in plasma, which can destroy fibrinolysin and thus protect prothrombin. For that reason, fibrinolysin can be added to plasma and there is no destruction of prothrombin. It is becoming increasingly evident that the complicated reaction systems involved in the blood clotting mechanism extend into far more general areas than had previously been anticipated and it requires work with purified factors to discover these new and unexpected relationships.

Michigan's Department of Health

Wm. De Kleine, M.D., Commissioner, Lansing, Michigan

SALMONELLA TYPES ISOLATED

The following Salmonella types were isolated by the Bureau of Laboratories, December 1, 1945 through November 30, 1946.

S. typhimurium	45
S. newport	23
S. paratyphi B	13
S. derby	12
S. typhimurium var. copenhagen	10
S. cholerae-suis var. kunzendorf	9
S. anatum	8
S. oranienburg	6
S. montevideo	5
S. bareilly	5
S. manhattan	4
S. give	4
S. oregon	4
S. paratyphi A	2
S. tennessee	2
S. bredeney	2
S. worthington	1
S. paratyphi B, var. java	1
S. california	1
S. panama	1
S. bovis morbificans	1
untypeable	1
Total laboratory isolations	160
Total Cases of Salmonella infection reported	76

These Salmonella types are all of human origin and do not include repeat tests or isolations of Salmonella typhi. There is a decided discrepancy between the number of positive isolations made for physicians and the number of cases of Salmonella infection reported to the health department. Salmonella infections were made reportable in March, 1944. Prompt reporting would be appreciated.

INCIDENCE OF COMMUNICABLE DISEASE

Disease	*December, 1946*	*December, 1945*	*Totals for 1946**	*Totals for 1945*
Diphtheria	30	77	385	630
Gonorrhea	911	941	12635	12565
Lobar Pneumonia	74	111	817	974
Measles	251	1016	42261	6328
Meningococcic meningitis	11	26	183	270
Pertussis	892	654	8115	5339
Poliomyelitis	54	13	1077	215
Scarlet fever	727	784	5976	9304
Syphilis	1336	1252	18051	16046
Tuberculosis	498	454	5547	5471
Typhoid fever	2	8	88	58
Undulant fever	9	8	135	246

*Provisional figures.

SIGNIFICANT FIGURES

In 1920, communicable diseases accounted for 34.6 per cent of the total deaths in Michigan. In 1945, that percentage was down to 9.7.

PRENATAL LETTERS REVISED

In January a set of revised prenatal letters was mailed to each physician in the state. These ten letters, co-sponsored by the Department of Health and the state medical society, are mailed (one each month) to any expectant mother who sends in a request card. Physicians may obtain a supply of request cards for their offices from their local health department.

STATE COUNCIL OF HEALTH

The quarterly meeting of the State Council of Health was scheduled for January 17 at the School of Public Health, University of Michigan. At the first meeting of the year attention is usually given to any changes in the state's rules and regulations for communicable disease control.

Henry F. Vaughan, D.P.H., Ann Arbor, is president of the council. Other members are C. L. Hess, M.D., Bay City; Harold E. Wisner, M.D., Detroit; Wesley H. Mast, M.D., Petoskey; and Kenneth A. Easlick, D.D.S., Ann Arbor.

FIFTH X-RAY UNIT ADDED

The fifth x-ray unit of the Department of Health went into operation December 16. This trailer-type unit will help meet the constantly growing demand for x-ray service which has resulted in all units being booked solid for six months or more ahead. The department hopes to intensify its industrial program by offering surveys on a regular annual basis.

NEWS OF PERSONNEL

E. S. Parmenter, M.D., has been appointed director of District Health Department No. 4, with headquarters at Rogers City. Dr. Parmenter is a native of that part of the state and has practiced in Alpena for several years.

* * *

Chester V. Tossy, D.D.S., has been appointed assistant director of the Bureau of Public Health Dentistry of the Michigan Department of Health. A graduate of the University of Minnesota, Dr. Tossy was for thirteen years on the staff of the dental division of the Children's Fund of Michigan. He served in the U. S. Navy during the war and since then has been in private practice in Detroit.

BLUE CROSS CONTINUES TO GROW

The latest figure on Blue Cross enrollment (September 30) shows a total membership of 24,390,763. The growth during the third quarter 1946 exceeded all previous third quarter enrollment figures. In the vanguard of the eighty-seven plans in the United States and Canada are Associated Hospital Service of New York, Massachusetts Hospital Service, Michigan Hospital Service, Associated Hospital Service of Philadelphia and Hospital Service Association of Pittsburgh, all with over a million subscribers.

Leaders in the percentage of population enrolled are: Hospital Service Association of Rhode Island with 63 per cent; Massachusetts Hospital Service with 46 per cent; and Group Hospital Service, Inc., of Wilmington, Del., with 45 per cent. The September figure gives Blue Cross one enrollee for every six persons in the United States.

SMOOTH LABOR

Demerol, the potent, synthetic analgesic, spasmolytic and sedative, relieves labor pains promptly and effectively without danger to mother and child. There is no weakening of uterine contractions, lengthening of labor, or postpartum complication due to the drug. Bad effects on the newborn are practically nil: no respiratory depression or asphyxia from too much analgesia of the mother. Simplicity of administration is another commendable feature.

Available in ampuls (2 cc., 100 mg.); vials (30 cc., 50 mg. / cc.).

WRITE FOR DETAILED LITERATURE

Narcotic blank required

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Woman's Auxiliary

REPORTS ON TB SPEAKING PROJECT

The sixth annual TB Speaking Project continued to improve over previous years. This year, sixty schools from forty counties sent in scripts for state judging. Last year, fifty-two schools from thirty-two counties participated.

There were twenty local broadcasts over nine radio stations, with a total of five hours and thirty minutes.

Bay, Houghton, Ingham and St. Clair counties had the largest number of school entries. In each of these counties the local Woman's Auxiliary to the Michigan State Medical Society and, in Bay and Ingham, the local tuberculosis associations were especially active in promoting the project. Local awards were also made in several counties.

The judges of the project were Mr. Andrew Kovace of the Michigan Tuberculosis Association, Mr. Harold Sponberg of the Speech Department, Michigan State College, and the Medical Auxiliary chairman.

The winners of both the first and second place awards were guests of the sponsors on December 20 at the time of the state broadcast over WKAR, the Michigan State College station.

Mrs. R. H. Alter of Jackson, president of the Woman's Auxiliary to the Michigan State Medical Society, presented the medals. Mr. T. J. Werle, executive secretary of the Michigan Tuberculosis Association, introduced the speakers.

The first-place winners broadcast their scripts, and the second-place winners were introduced over the radio. All teachers and names of those received honorable mention were announced.

Junior high school winners on the subject, "TB Concerns You and Me," were: first place, Jo Ann Koski, Houghton; second, Sally Butts, Hemmeter School, Saginaw.

Senior high school winners on the subject "Our Protection Against TB," were: first place, Colombe Yeomanns, Holland; second, Patrick Dakin, Resurrection School, Lansing.

Winners on the subject, "Diagnosis: Tuberculosis," were: first place, Louise Fifelski, Wayland; second, Ron Sinclair, Jackson.

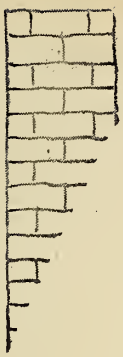
On the subject, "Light of Progress," the winners were: first place, Ann Kontas, Sexton High, Lansing; second, Marylyn Greene, Hancock.

Representatives from the following schools received honorable mention: Unionville, Cheboygan, Port Huron, Algonac, Bay City, Central High, Galesburg, Bear Lake, Hancock, Marquette, John D. Pierce High, Kaleva Rural Agricultural School, Holland, Eben Junction.

This project over the past few years has focused the attention of Michigan youth on a very important public health problem. This has been possible only through the intensive efforts of teachers, students, tuberculosis association workers and members of the Woman's Auxiliary to the county medical societies, to all of whom the entire credit is due.

MRS. MILTON SHAW, *Chairman.*

Say you saw it in the Journal of the Michigan State Medical Society



"eating of curds and whey"

Miss Muffet's traditional meal should be supplemented with vitamin D, for it has been clearly demonstrated that children require vitamin D not only during their first two years but for as long as growth persists.[1] Upjohn makes available convenient, palatable, high potency vitamin D preparations derived from natural sources in forms to meet the varied requirements from earliest infancy through adolescence.

1. Am. J. Dis. Child. 66: 1 (July) 1943.

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In Memoriam

James C. Abrams, M.D., Calumet, was born in Allouez, and received his elementary education in the Calumet public schools. He received his B.S. degree at Valpariso University in 1897 and his doctor of medicine degree at Northwestern University Medical School in 1901. He practiced continuously until his death in Calumet. Dr. Abrams died on December 16, 1946.

* * *

Sylvester L. Ballard, M.D., Grayling, formerly of Bay City, was born April 4, 1881 in Pioneer, Ohio. He was graduated from the Michigan College of Medicine and Surgery in 1905; served as a captain in the army medical corps during World War I; served as city commissioner in Bay City from 1925 to 1930. Doctor Ballard died in Bay City on January 8, 1947.

* * *

Frank F. Marshall, M.D., L'Anse, was born in Lawrence, Massachusetts, March 23, 1880. He received his doctor of medicine degree from Harvard Medical School in 1911. He came to the Upper Peninsula of Michigan shortly after his internship. He served with the United States Army Medical Corps during World War I, during two years of which service he was commanding officer of a hospital for contagious diseases in France. Dr. Marshall died in Marquette on December 16, 1946.

* * *

William W. Ryerson, M. D., Port Huron, was born in Waterford, Ontario, September 3, 1888. He was graduated from Detroit College of Medicine in 1911 and opened his practice of medicine in Port Huron the following year, after completing his internship. During World War I he served in the United States Army Medical Corps at Embarkation Hospital No. 2 near Jersey City, N. J., and at Camp Mills, Garden City, Long Island City, N. Y. Dr. Ryerson died on December 6, 1946.

* * *

Frank T. McCormick, M.D., Detroit, was born at Barrie, Ontario, January 20, 1880. He was graduated from the University of Michigan Medical School in 1905 and practiced in Detroit, after completing his internship, until his death. He was a Fellow of the American Association of Industrial Physicians and Surgeons. Dr. McCormick died in Detroit on July 26, 1946.

* * *

David N. Robb, M.D., Ypsilanti, was born in Belleville, May 26, 1898. He was graduated from the Detroit College of Medicine in 1929, and after completing his internship in 1930, he located in Ypsilanti where he practiced until his death. He was former coroner for Washtenaw County. Dr. Robb died on November 13, 1946.

Say you saw it in the Journal of the Michigan State Medical Society

EASE AND ECONOMY OF USE

Specification of CARTOSE* as the mixed carbohydrate for infant feeding formulas provides ease and economy of use. The liquid form of this milk modifier permits rapid, accurate measurement, thereby avoiding waste.

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What's What

Harold F. Falls, M.D., Ann Arbor, is the author of an original article entitled "Retinoblastoma" which appeared in *JAMA* of January 18, 1947.

* * *

The Twelfth Assembly and Convocation of the United States Chapter, International College of Surgeons, will be held at the Palmer House, Chicago, September 29, 30 —October 1, 2, 1947.

* * *

Federal Government grabbed 82 cents of every Michigan tax dollar last year, as compared with 48.2 per cent in 1940 and 28.7 per cent in 1930, according to Department of Revenue figures.

—*Survey Digest,* December, 1946.

* * *

The Kalamazoo Academy of Medicine was host on January 9 to W. M. Stanley, M.D., of the Rockefeller Institute for Medical Research. The recent Nobel Prize winner spoke to the Academy of Medicine on "Studies on Purified Influenza Virus."

* * *

The Michigan Pathological Society held its February 8 meeting at Henry Ford Hospital, Detroit. Granville Bennett, M.D., chairman of the Department of Pathology, University of Illinois, conducted a seminar on "Diseases of Tendons and Joint Structures."

California Health Insurance Drive.—Republicans are in control of both the Senate and Assembly of California for the first time in many years. Governor Earl Warren again plans to propose a compulsory health insurance bill—so another bitter fight on this measure can be predicted.

* * *

Uniform Fee Schedule for Governmental Agencies.—Question: Under "visits" does Item 2204 which reads, "Visit out of city for examination or treatment (over 3 miles from office)," allow for mileage one way or both ways?

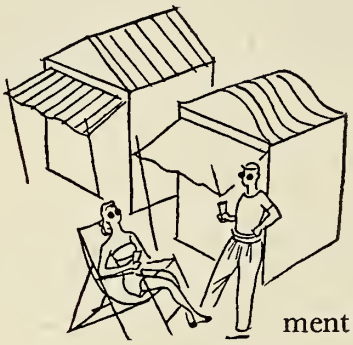
Answer: The mileage is for one way only.

Committee on Uniform Fee Schedule
for Government Agencies.

* * *

L. G. Christian, M.D., Lansing, was one of the guest speakers on the program of the National Conference on Medical Service, February 9, at the Palmer House, Chicago. Dr. Christian participated in an open forum, with three other nationally known speakers, on the topic "Modern Influences in Medical Practice: Undergraduate Medical Education, Trends Toward Specialization, General Practitioners in Hospitals, Hospital Staff Organization."

(Continued on Page 236)



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THE PROTEIN of Similac is rendered soluble to a point approximating the soluble protein in human milk.

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THE MINERALS in Similac are adjusted to closely approximate the minerals of breast milk.

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MEN'S WEAR • 617 WOODWARD

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(Continued from Page 232)

Error in slide rule.—Ciba Pharmaceutical Products, Inc., Summit, New Jersey, are much concerned regarding the error in the slide rule they distributed to all physicians in Michigan, recently. A correction of the slide-rule error has been forwarded to physicians generally, with the request that the correction be made, or that they write Ciba for a copy of the corrected slide rule.

* * *

"Eighty voluntary health insurance plans in thirty-three states cover more than four million," is the subject of an article in JAMA of January 18, 1947.

"This pioneering task has just begun," states Thomas A. Hendricks, secretary of the Council on Medical Service, AMA. In this story Mr. Hendricks outlines how the Council is set up to do the job of encouraging the development of new plans, keeping the profession informed as to developments, and helping to increase the enrollment of plans already established.

* * *

Henry N. Harkins, M.D., who for a number of years was associate surgeon at the Henry Ford Hospital, and who left the Henry Ford Hospital to become associate professor of surgery with Dr. Alfred Blalock at Johns Hopkins Hospital and University in Baltimore, Maryland, has now accepted the position as professor of surgery and executive officer of the Department of Surgery at the University of Washington in Seattle. Dr. Raymond Allen is now president of the University of Washington. Dr. Harkins was a member of the Michigan State Medical Society.

* * *

The Annual President's Dinner of the Ingham County Medical Society was held January 16. Retiring President Franklin L. Troost, M.D., incoming President Robert S. Breakey, M.D., and President-elect Oliver B. McGillicuddy, M.D., were introduced by Toastmaster LeMoyne M. Snyder, M.D.

H. J. Stafseth, D.V.M., Ph.D., of Michigan State College, spoke on "A Little of This and That from China." One hundred and ten members of the Ingham County Medical Society, together with their ladies, were present.

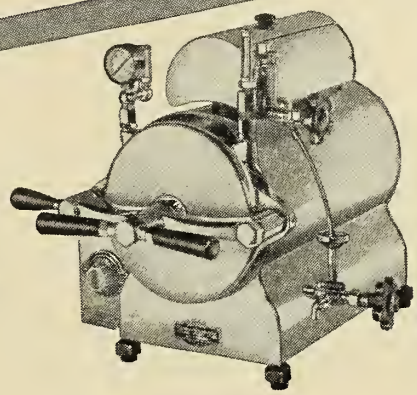
* * *

The First-Sixteenth Councilor Districts' meeting is scheduled for Detroit on March 31, with C. E. Umphrey, M.D., Detroit, councilor of the First District, presiding. The meeting, a joint session at the Wayne County Medical Society, includes the following program: "Medical Matters in Our State" by William A. Hyland, M.D., Grand Rapids, president, Michigan State Medical Society; "The Federal Hospital Program" by L. Fernald Foster, M.D., Bay City, secretary, Michigan State Medical Society; "Some Legislative Problems Facing Medicine" by E. F. Sladek, M.D., Traverse City, chairman of MSMS Council; and "Modern Medical Public Relations" by E. R. Witwer, M.D., Detroit, councilor of the Sixteenth District.

(Continued on Page 240)

FREE of the Danger Zone in '47?

You can never tell when the blood stream of a patient carries spore-bearing bacteria. Guard against the danger of cross-infection by autoclaving all instruments and other materials that come in contact with any blood stream.



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DANGER LURKS BELOW 250° MOIST HEAT

Boiling does not destroy spore-bearing bacteria. Chemicals may be effective if maintained long enough. Autoclaving (moist heat at 250° F.) is the practical answer. Write today for your copy of the informative booklet, "A-B-C of Autoclave Sterilizing."

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(Continued from Page 236)

Rehabilitation.—Governors of all states have been called upon for co-operation in stepping up the national rehabilitation program for the disabled. In letters sent to the governors during November, Federal Security Administrator Watson B. Miller advised that the program for the next fiscal year calls for a 300 per cent increase over last year's mark. To accomplish this increase, state appropriations of $12,000,000 for the 1947-48 fiscal year would be needed, as against $6,750,000 of state funds available for rehabilitation purposes during the current fiscal year.

The federal government, through the Office of Vocational Rehabilitation, furnishes approximately 70 per cent of the money spent by the states in vocational rehabilitational work. Most states will have to increase their appropriations to participate fully.

* * *

Seal of Acceptance for Medical Service Plans.—Here is the Seal of Acceptance of the Council on Medical Service. To date, fifty-two plans have been approved by the Council and may use the Seal of Acceptance in their literature. Approval of four plans is still pending. Use of the Seal is granted to those prepayment medical care plans which meet the Standards of Acceptance as set forth by the Council.

Of special interest in this regard is the fact that a number of large employers whose employes live in several states have indicated an interest in the approval program as a basis for considering prepayment programs for their plants.

* * *

Senators Taft, Smith and Ball conferred with a committee of the AMA on December 27 in Washington on redrafting their bill of last year (S. 2143). It is our understanding that the new bill will have the following features: (1) a separate government agency for its administration, outside Federal Security or Public Health Service; (2) administered by a physician, to be appointed by the President, preferably from men in private practice; (3) Advisory Committee with more than advisory powers, also to be appointed by the President; (4) means test to be applied on state level; and (5) the administration to be on state level, according to plans formulated by the separate states. An appropriation of $200,000,000 will be made available to be apportioned among the states according to a formula similar to that contained in the hospital construction law. The bill will be introduced in the Senate as soon as it can be drafted.

* * *

Country Editors Overwhelmingly Opposed To Government-Sponsored Medical Insurance.—What does the voice of America say about the devices of state socialism? The *American Press* recently polled the outstanding editors in 1,000 rural communities to ascertain their views

(Continued on Page 244)

The combined use of an occlusive diaphragm and vaginal jelly remains, in the published opinions of competent clinicians, the most dependable method of conception control.

Dickinson[1] has long held that the use of jellies alone cannot be relied upon for complete protection. It is noteworthy that in the series of patients studied by Eastman and Scott[2], an occlusive diaphragm was employed in conjunction with a spermicidal jelly for effective results. Warner[3], in a carefully controlled study of 500 patients, emphasized the value of a diaphragm.

In view of the preponderant clinical evidence in its favor, we suggest that physicians will afford their patients a high degree of protection by prescribing the diaphragm and jelly technique.

You assure quality when you specify a product bearing the "RAMSES"* trademark.

1. Dickinson, R. L.: Techniques of Conception Control. Baltimore, Williams and Wilkins Co., 1942.
2. Eastman, N. J., and Scott, A. B.: Human Fertility 9:33 (June) 1944.
3. Warner, M. P.: J. A. M. A. 115:279 (July 27) 1940.

gynecological division

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Tablet, **No Heating** Method for Quick Qualitative Detection of Albumin

CLINITEST

Tablet, **No Heating** Method for Detection of Urine-Sugar

Both products provide simple, reliable tests that can be conveniently and safely carried by physicians and public health workers. They are equally satisfactory for large laboratory operations. Clinitest is also available in special Tenite plastic pocket-size set for patient use.

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In bottles of 36 and 100.

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Plastic Pocket-Size Set (No. 2106)
Includes all essentials for testing.

Complete information upon request

Distributed through regular drug and medical supply channels.

AMES COMPANY, Inc.
ELKHART, INDIANA

(Continued from Page 240)

about the most publicized proposals offered by the leaders of the incoming Congress. The news and views of these editors are read by nearly seventy million persons. To the question: Do you think Congress should enact legislation for Government-sponsored medical insurance? The answers were: 12 per cent, yes; 80 per cent, no; 8 per cent, no answer. The "no" vote was exactly the same as in a similar poll by the *American Press* in September, 1945. What, no converts from all this W-M-D publicity? Page Boas, Falk, and Davis!

—Marjorie Shearon, Ph.D.
Washington, D. C.

* * *

Postgraduate Anatomy.—To meet the need for additional work the following courses in Regional Anatomy will be offered to the medical profession at Wayne University College of Medicine.

1. The Trunk, on Wednesday afternoons, from 1:00 to 5:00 (February 19 through May 28).
2. The Extremities and Back, on Thursday afternoons, from 2:00 to 5:00 (March 6 through May 29).
3. The Head and Neck, on Friday afternoons, from 1:00 to 5:00 (March 7 through May 30).

The courses, open to any doctor of medicine, will consist of lectures, demonstrations and dissection. The fee is $50 for each course. Registration should be made in the office of the Director of Graduate Medical Education at the College of Medicine before February 12, 1947.

* * *

The Committee on State Veterans Affairs, created by the 1946 MSMS House of Delegates, has been appointed by President William A. Hyland as follows: L. E. Sevey, M.D., *chairman,* Grand Rapids; G. C. Penberthy, M.D., Detroit; W. W. Babcock, M.D., Detroit; C. W. Brainard, M.D., Battle Creek; O. A. Brines, M. D., Detroit; William Bromme, M.D., Detroit; W. C. C. Cole, M.D., Detroit; W. C. Ellet, M.D., Benton Harbor; H. B. Fenech, M.D., Detroit; James Fyvie, M.D., Manistique; J. V. Fopeano, M.D., Kalamazoo; R. F. Hague, M.D., Flint; S. W. Hartwell, M.D., Muskegon; J. E. Ludwick, M.D., Jackson; K. S. McIntyre, M.D., Hastings; H. C. Mitchell, M. D., Grand Rapids; W. E. Nesbitt, M.D., Alpena; C. I. Owen, M.D., Detroit; F. H. Power, M.D., Traverse City; C. W. Reutter, M.D., Bay City; Paul Schrier, M.D., Kalamazoo; J. M. Sheldon, M.D., Ann Arbor; R. W. Teed, M.D., Ann Arbor; J. M. Wellman, M.D., Lansing, and Stuart Yntema, M.D., of Saginaw.

* * *

A new tablet for purifying water in the soldier's canteen, which is considered superior to the chlorine-type tablets used during the war, has been announced by the War Department.

With iodine employed instead of chlorine, the new tablets make the drinking water less objectionable in taste and odor. Tests have shown that the iodine-containing tablet has greater sterilizing flexibility, in that it can be used under a wide range of conditions. It is also more suitable and dissolves more quickly than its predecessor. This tablet was developed by scientists of the Army Medi-

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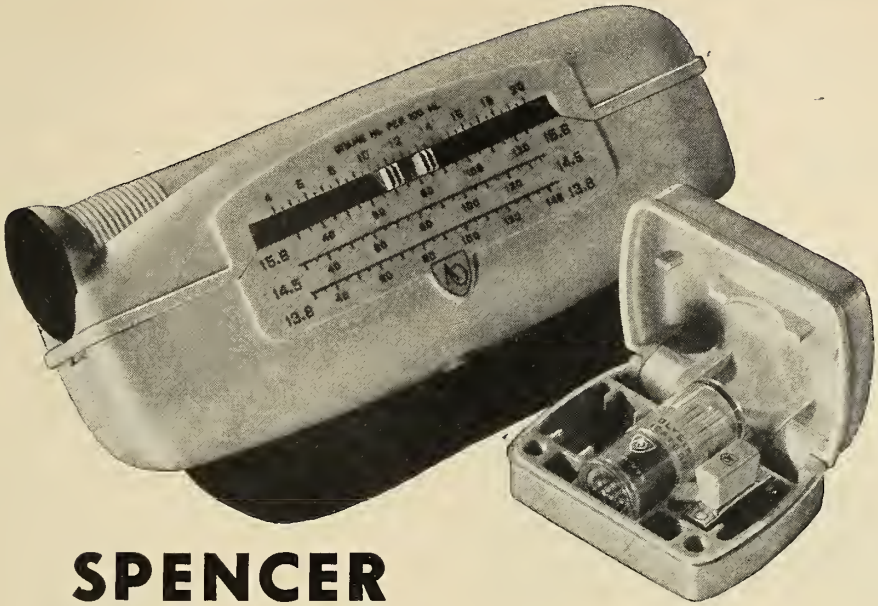

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(Continued from Page 244)

cal Department, Quartermaster Corps and Corps of Engineers.

When the chlorine-containing tablets were dissolved in water, soldiers complained that they made the water unpleasant to the taste. It was found that, even with strict supervision, it was sometimes difficult to prohibit the soldiers from drinking water from streams or wells of questioned purity.

* * *

Michigan representatives on AMA broadcast.—Michigan will have a part, April 5, in the current radio series of the AMA, "Doctors Now and Then." It will be broadcast on the coast-to-coast network on the NBC at 4:00 PM, EST. Each program of the AMA series dramatizes the life and times of a doctor of medicine in one region of the United States and contrasts him with present times. Michigan will be represented April 5, at which time incidents in the life of Dr. Douglas Houghton, sometimes referred to as "The Little Doctor" and "The Great Geologist," will be dramatized. The City of Houghton, Michigan, and Houghton Lake in this state are both named after Dr. Douglas Houghton, who practiced medicine in Detroit and was one of its first mayors. A contrast will be drawn between the health conditions of his day and those of today. Following the dramatization, a three-minute comment on present conditions will be made by J. Milton Robb, M.D., Detroit, past president of the Michigan State Medical Society, who will be "picked up" at the Detroit station, WJR.

* * *

EMIC Babies.—Somewhere in the United States on or about Armistice Day, the millionth baby under the EMIC program arrived. Another 100,000 were on the way. In addition, 180,000 of the babies already born have received or are receiving additional medical, hospital or nursing care during the first year of their life.

The Children's Bureau, which sponsors the program administered by the state health departments, reports the cost to the government at almost $100,000,000 at the rate of about $100 for a maternity case and $65 for an infant's case.

At the peak of the program, one out of every seven infants born were EMIC babies. Between 40,000 and 45,000 maternity and infant cases were being authorized each month. Now the total authorizations are about 15,000 a month. Of the EMIC babies nine out of ten were hospital born. The proportion of hospital births among all babies born in the United States was seven and one-half out of ten in 1944.

* * *

The Sixth Councilor District meeting was held at the Elks Club, Flint, on January 14. W. Z. Rundles, M.D., Flint, president of the Genesee County Medical Society, presented R. C. Pochert, M.D., of Owasso, councilor of the Sixth District, who acted as toastmaster. R. S. Morrish, M.D., Flint, immediate past president of the Michigan State Medical Society, welcomed the guests to Flint. Carleton Dean, M.D., Lansing, director, Michigan

(Continued on Page 248)

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(Continued from Page 246)

Crippled Children Commission, spoke on "Rheumatic Fever Control in Michigan." President William A. Hyland, M.D., Grand Rapids, spoke on "What's Going On, Medically, In Our State." L. Fernald Foster, M.D., Bay City, MSMS secretary, presented facts on the federal hospital construction program. William J. Burns, Lansing, MSMS executive secretary, presented "Some Legislative Problems Facing Medicine," and H. W. Brenneman, Lansing, MSMS public relations counsel, spoke on "Modern Medical Public Relations." The meeting was attended by 103 doctors from all parts of the Sixth Councilor District.

* * *

Guide for Physical Examinations of Veterans.—In most instances where the question of degree of disability is raised by a veteran, or the existence of some disease or disability not admitted to exist by the Veterans Administration is at issue, it is necessary for the veteran to submit medical evidence in support of his claim. Quite frequently this medical evidence submitted by the veteran is wholly inadequate and is of little or no importance.

This condition is not the result of a lack of knowledge of medical science by the physician who substantiates the evidence for the veteran, but is a factor brought to the forefront by the use of a peculiar medical nomenclature used by the Veterans Administration in physical examinations for rating purposes.

A pamphlet entitled "Guide for Physical Examinations" has been compiled by George W. Cameron, Chief of Claims Service, Department of Veterans' Affairs, State of Alabama, which material may be of interest and help to Michigan doctors of medicine.

Copies are available by writing the Michigan *Office of Veterans' Affairs,* 411-15 W. Michigan Ave., Lansing 15, Michigan.

* * *

Speakers on the "Doctor of Medicine" Program over Radio Station CKLW on Fridays at 12:45 PM (Sponsored by the Hack Shoe Company) have included: September 13, Joseph G. Molner, M.D., Detroit, "Children's Health;" September 20, Ray S. Morrish, M.D., Flint, "The Medical Convention In Respect to Patient;" September 27, Ralph A. Johnson, M.D., Detroit, "Hypertension;" October 4, A. E. Catherwood, M.D., Detroit, "Maternal Care;" October 11, L. Fernald Foster, M.D., Bay City, "The National Health Problem and You;" and from Detroit only, October 18, Andrew S. Brunk, M.D., "Cancer;" October 25, A. E. Schiller, M.D., "The Skin You Love To Touch;" November 1, Wyman C. C. Cole, M.D., "Child Care;" November 8, P. L. Ledwidge, M.D., "Rheumatic Fever, Public Enemy No. 1;" November 15, Donald C. Somers, M.D., "Present Concepts of Orthopedic Surgery;" November 22, L. W. Wiren, M.D., "What Is A Psychiatrist;" November 29, C. E. Umphrey, M.D., "Care Of The Feet and Legs;" December 6, Frank H. Purcell, M.D., "Orthopedic Surgery;" December 13, William M. Tuttle, M.D., "Pulmonary Tuber-

(Continued on Page 254)

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OPERATIVE GYNECOLOGY. By Richard W. Te Linde, M.D., Professor of Gynecology, Johns Hopkins University, and Chief Gynecologist, Johns Hopkins Hospital. With 309 illustrations in black and white, and fifteen subjects in full color on nine plates. Philadelphia: J. B. Lippincott Company, 1946.

Gynecology has become a specialty of itself, and as such involves many angles of diagnosis and treatment. It involves urological conditions, psychiatric problems, surgical technique, anesthesia, and many conditions which must be investigated. The author has incorporated all that in his new book. This is a fully executed text describing in detail all types and forms of disease with its diagnosis and numerous surgical illustrations and descriptive instructions. All the newest developments are given, and after each chapter a short but sufficient bibliography. Surgery of the abdominal wall, intestinal surgery, and congenital defects are all given careful attention. This volume is very complete, and is worthy of place on the book shelves of surgeons, gynecologists and internists.

THE DIFFERENTIAL DIAGNOSIS OF JAUNDICE. By Leon Schiff, Ph.D., M.D., Associate Professor of Medicine, Department of Internal Medicine, University of Cincinnati Medical School. Director Gastric Laboratory, Cincinnati General Hospital. Chicago: The Year Book Publishers, Inc., 1946. Price $5.50.

The author, after contacts for over twenty years with students and practitioners, and in an attempt to fulfill manifest needs, has written a book to place at their disposal an authoritative discussion of the clinical and pathological features of jaundice. This condition occurs in so many different diseases, and has so many implications that it must be treated almost as a disease entity. The classifications of jaundice are emphasized, whether hepatogenous, neoplastic, et cetera. Systemic infections, acute yellow atrophy, Weil's disease, cirrhosis, carcinoma are all described at length. Much attention is given to physical examination and various laboratory methods, x-ray, urobilin determination, and liver biopsy. The latter is very carefully described and evaluated. The book is well worth careful study by the diagnostician and the surgeon.

MUSCLE TESTING—Techniques of Manual Examination. By Lucille Daniels, M.A., Director and Associate Professor of Physical Therapy, Stanford University; Marian Williams, M.A., Assistant Professor of Physical Therapy, Stanford University; and Catherine Worthingham, M.A., Director of Professional Education, The National Foundation for Infantile Paralysis, Inc. Designed and illustrated by Harold Black with 349 diagrammatic line drawings. 189 pages. Philadelphia and London: W. B. Saunders Company, 1946. Price $2.50.

Muscle action and testing is important in treatment of disease involving paralysis or impairment of action such as poliomyelitis. This book gives in sketch form the muscles involved in the making of motions and actions. Skeletal segments are illustrated with the muscles shaded in, and on the opposing page the picture of the performance of four tests developing that motion or action. The first is "normal and good"; the second picture shows "fair," and the third "poor," and the last shows "trace and zero." Sometimes there are two or three illustrations of each reaction. This book would be invaluable in the

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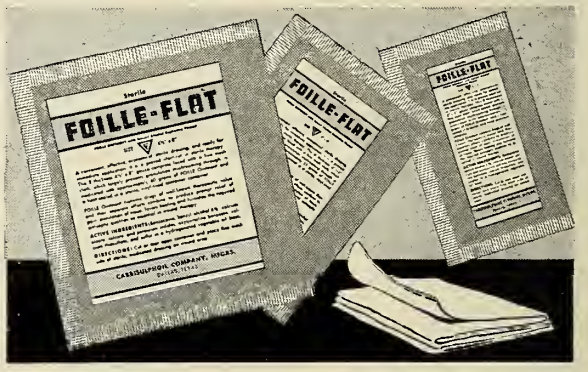

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outlining and conducting of recouperative measures in treatment of infantile paralysis and certain other forms of paralysis.

MEDICAL RESEARCH. A symposium edited by Austin Smith, M.D., Secretary, Council on Pharmacy and Chemistry; Director, Therapy and Research, American Medical Association. 17 illustrations. Philadelphia: J. B. Lippincott Company. 1946. Price $5.00.

This is a collection of various papers regarding research with especial relation to medicine. The articles are devoted to the mental attitude, motives, training, and objects to be obtained. Some guiding principles are quoted such as "If you do something of significance in your work, write it up and send it to a good journal." Industrial expenditures are a great factor in medical research. Research laboratories are discussed, giving the function, buildings, equipment, et cetera, but much valuable research has been done with the most inadequate furniture and facilities, but with the most important factor an observing mind. Publication of results is important. Methods of study should include photography, especially modern color records. Ten color illustrations, very striking, are given to emphasize the text. A valuable book for the individual having in mind any form of research, because of the valuable hints and cautions.

MEDICAL USES OF SOAP. A symposium edited by Morris Fishbein, M.D., Editor of *The Journal of the American Medical Association*. 41 illustrations. Philadelphia: J. B. Lippincott Company, 1946. Price $3.00.

This book was reviewed before, but in its second printing much new material is used, and an entirely new chapter is added on "The Surgical Uses of Soap." Chemistry and manufacture of soap is outlined. New detergents are also described. Edwin P. Jordan, M.D., Associate Editor of *The Journal of the American Medical Association,* contributed the new chapter. This book is interesting and valuable in giving us so much information about a commonly used article about which we do not know too much.

THE CHALLENGE OF POLIO. The Crusade Against Infantile Paralysis. By Roland H. Berg. Introduction by Basil O'Connor, President, The National Foundation for Infantile Paralysis, Inc. New York: The Dial Press, 1946. Price $2.50.

This book is a history of infantile paralysis and man's fight to overcome it. Ancient Egyptian murals showed crippling obviously from infantile paralysis, and a skeleton of 3700 B.C. showed bone formation indicative of this disease. It has occurred in other parts of time and place, but the first actual description of the disease was in 1784. The epidemic form only appeared in very recent times, 1894, in Otter Creek, Vt. It was in 1916 that the import of the disease became apparent. This book tells the story, mentions the story of F.D.R. and his affliction. It tells of his exhausting experiences previous to his attack, and the establishing of treatment at

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Warm Springs. It tells of the search for a germ, and for a cure. The virus has been isolated, and treatment for the disease instituted. It has been found that of a group of persons exposed, those with excessive tiring or exposure are the ones to be attacked the most viciously. The story of tonsil connection is given with apparent conclusive "proof" that recent tonsillectomies predispose to the infection. Sewage contamination is stressed, but as a method of flies getting contaminated.

Pediatrists and internists should be familiar with the contents of this book.

WHAT'S WHAT

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culosis;" December 20, Frank A. Weiser, M.D., "Health at Forty and Beyond;" December 27, Milton L. Sorock, M.D., "Nurses in War and Peace;" January 3, C. D. Selby, M.D., "It's In The Air;" January 10, L. W. Hull, M.D., "Physical Health Examination;" January 17, Charles W. Peabody, M.D., "Orthopedics For The Not-So-Young;" January 24, Martin H. Hoffmann, M.D., "True Facts on Epilepsy."

DERMATITIS MEDICAMENTOSA

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recognized that urticaria was a fairly common complication of penicillin therapy. While the urticaria is often mild and transient, in many instances it has been of severe degree, the eruptive elements being extremely large and extensive, and the pruritus intolerable. In such cases, control has often been difficult to attain, as, in some instances, the use of adrenalin, ephedrine, benedryl or pyribenzamine has failed to relieve the symptoms. The delayed character of this urticarial reaction is important, as commonly it may not appear till some days have elapsed since discontinuance of the drug.

Other types of cutaneous reactions to the use of penicillin have also been observed, as angioneurotic edema, miliaria-like eruptions, erythema nodosum, and erythematovesicular eruptions which may simulate dermatophytosis. In connection with the latest named type of eruption, it is interesting to note that several observers have indicated that previous fungus infections of the skin predispose toward the development of reactions to penicillin, usually with the development of the manifestations at the sites of the lesions of earlier eruptions of mycotic origin.

Reactions to penicillin may appear shortly after the exposure to the drug, presumably due to an inherent sensitivity or to a previous fungus infection, or may not appear until later, due to a developing sensitization.

Inactive cases of tuberculosis which are revealed by x-rays need continuous observation and follow-up to be assured that they do not again become active.

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1. Duncan, G. G.: M. Clin. North America 30:349 (March) 1946.
2. Peters, J. P., and Elman, R.: J.A.M.A. 124:1206 (April 22) 1944.

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The Public Responsibility of Medical Societies

Creighton Barker, M.D.
Executive Secretary, Connecticut State
Medical Society

IT IS a pleasure to have this opportunity to be with you, and to bring greetings from the Connecticut State Medical Society to the Michigan Society, with our best wishes for the success of this Conference and all the good things you undertake. In Connecticut we recognize the Michigan Society as one of the great state medical societies in America, and often we envy you for the things you are able to do. I have frequently found personal inspiration in your progress and leadership. May you continue to prosper.

It is perhaps a little early in the morning to be sentimental but unless I can have you feel a part of the past and the tradition in which I have grown up, some of the things I shall have to say may lose their true significance.

It was my privilege to serve for nearly fifteen years as the secretary, or clerk as it is traditionally called, of what is generally conceded to be the second oldest extant medical society in our country. It is the New Haven County Medical Association which had its first meeting on the fifth of January, 1784. It has been in operation for 163 years without interruption, and the complete records of the Association have been preserved. The Connecticut State Medical Society stemmed from this Association, and in 1792 it received the first private charter granted by the General Assembly of the State of Connecticut. It is not my purpose to give an historical review of these two venerable organizations. It is worth while, I think, to understand the background of the organization of our early medical societies and the forces that motivated them and occasionally to appraise these motives in the light of changing times.

It is a long way back to 1784 and not easy for us to put ourselves in the environment of that time. It was only a month before the day of the first meeting of this medical association that General Washington bade farewell to his officers in the great room of Fraunce's Tavern in New York to return to the life of a country gentleman at Mt. Vernon. There was no United States and save for its part in the Federation of Perpetual Union with a few other colonies, Connecticut was an individual colony governed by its own constitution which had been adopted in 1639. No one quite knew what the people were going to do with their newly won independence. In Massachusetts an alert and advanced medical profession had completed the organization of a society three years before, in 1781, and in New Jersey even earlier than that, but the New Jersey progress was interrupted for many years.

Looking back through the perspective of history, we see two tributary streams of interest and endeavor uniting for the founding of these early medical societies. One of these tributaries was fed from the turbulent spring of enthusiasm for an independent and stable government, and the other had its origin in the well-rooted aspirations of the people for a wider and deeper culture. It was a combination of the desires to further the usefulness of medicine in their new country and to improve themselves which moved our forebears to found these institutions of which we are now so proud.

As the country expanded and wide areas of settlement developed, inevitably the physicians in the new states followed the example they had known at home and founded medical societies on each new frontier. It seems to me quite clear that there were always these two prime motives: one, the realization of a responsibility to society, and the other, a desire to improve their own knowledge and skill.

I would like to go back for a few moments and enumerate briefly some of the public accomplishments of the medical society in Connecticut, not because it is an extraordinary record, but because it is typical of the public contributions made by many other societies. In 1810 the Society, in co-operation with Yale College, founded the Yale School of Medicine. Then, with intervals of only

(Continued on Page 270)

Read at the Annual County Secretaries and Public Relations Conference of the Michigan State Medical Society, Detroit, February 2, 1947.

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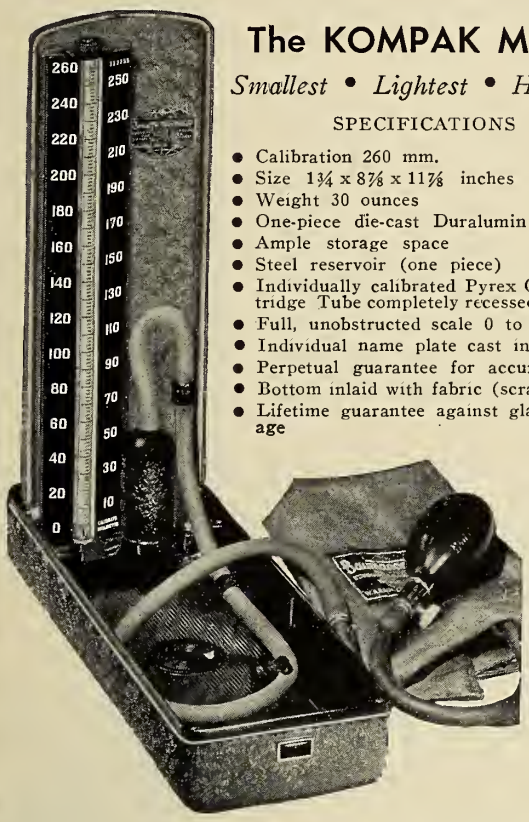

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(Continued from Page 268)

a few years, came the first school for the education of the deaf in America; one of the earliest hospitals for the care of the insane, and a general hospital to provide clinical material for the new medical school. Later, the Society moved for the establishment of the State Department of Health and legal provisions for medical licensure. It advocated and actually aided in the building of the first institution for the care of the feeble-minded and, at a time when sanatorium care of tuberculosis in our climate was not quite approved, it took the leadership in starting the sanatorium which was the beginning of our splendid public program for the control of tuberculosis. In each of these efforts the physicians of the state, through the State Medical Society, saw and understood their responsibilities and the need for their services in directing measures for the public good.

As the years went on and society became more complicated, it was to be expected that other agencies would increase their interest in the public weal so that the part played by medical societies was not as conspicuous, but nonetheless the need for their interest continued and their influence was felt for more than a century. I believe that the events of the past dozen years have served to deepen our perspective and bring us to the realization that our public services are now more important than ever before.

It is positive action that is required, not simply defensive and opposing tactics. During the recent years of new political philosophies, medicine was caught somewhat off guard and perhaps for a time it was indifferent; in any case it was forced into a defensive position. We should be out of that corner now, and I hope the wise leaders of medicine in your state, and ours, as well as in the national field, will constantly have before them a firm realization of the public responsibilities of our medical societies and be vigorous and wise and unremitting in the acceptance of that responsibility.

The political changes in our country since 1933 are usually seen as the growth in executive power, perhaps the power of one man, but such analysis overlooks the fact that these changes were a part of a world retreat from responsible representative government which began after World War I more than twenty-five years ago because the people lost interest in their governments. It was not just a political party that brought it about; the time was ripe for what happened, and the stage was set. Our country alone has survived, still believing in the principles of the republic, and we survived because we are young and strong and still have individual self-reliance and thrift and ambition, but we need even greater strength and faith.

Medical service can no longer be looked upon as a private and proprietary enterprise because it comes very close to being a public utility. But unlike public utilities, medical service is largely and uniquely provided by individuals; it is a project of individual skill and not of capital, and because of this has been subject to government regulation only in the slightest degree. What the future may hold in this connection is giving medicine concern, for there is now sharp interest in medical care from government. I believe you will agree that it is federal interference which alarms us, for most physicians, inded most Americans, are exponents of states' rights and are resentful of the intrusion of federal domination into our local affairs. There are innumerable precedents and philosophies for this attitude and we may not be far from right in the opinion that this strong individuality among the states has been the broad base which has supported the only thoroughly democratic government in the world.

It is at the state level where medical societies can be of the greatest public and political service. Not long ago I made a statement which was questioned by some but I would like to repeat it here, that under careful management it is possible for our societies to develop positions as quasi-governmental bodies, and the more nearly they approach this, always maintaining their independence and autonomy, the more useful they will be. There are many ways in which a medical society can be of valuable public service. In fact, it seems sometimes that there are functions of government which cannot be done as well by any other agency, and if a society sees and accepts these responsibilities unselfishly it will rate high in public confidence and esteem and achieve the highest objective of medical organization.

All of our states are engaged in activities having to do with the health and welfare of the people, and in one way or another government provides medical care. The planning and direction of these programs lies with citizen boards and the

(Continued on Page 272)

PLANNING · NOT LUCK

Neo-Iopax

Planning—not luck—is responsible for the pure, crystal-clear solution of NEO-IOPAX for urography. Every precaution known for obtaining a sterile fluid, completely free from foreign particles, is taken with this contrast medium during its production. And when NEO-IOPAX is ampuled it must pass before a corps of specially trained inspectors whose sole task is to detect and reject any solution containing the least visible trace of extraneous matter.

A final inspection by the physician himself before intravenous or retrograde injection is invited by the water-clear glass ampule in which NEO-IOPAX is dispensed.

NEO-IOPAX, disodium N-methyl-3,5-diiodo-chelidamate, is supplied as a stable, crystal-clear solution in 50 and 75 per cent concentrations.

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(Continued from Page 270)

basis of a good relationship with a state government is to have the state medical societies in a position to be consulted about appointments to these boards and agencies, and wise and helpful people should be selected to serve in these positions. Once this honorable extension of medical society influence is established, it becomes quite difficult to put into effect measures which are not acceptable to medicine because representatives of medicine will always be included in the planning and drafting of regulations and legislation. Also, when health and welfare legislation is proposed by the public, it usually has some relationship to an existing government agency, either to change its purposes or expand its functions. Physicians on the boards of such agencies have an opportunity to analyze and understand the effects of the proposed measures and oppose them if they are not sound, thus adding the weight of government to the side of medicine and not leaving the profession to stand alone as a defensive minority. This infiltration of government with representatives of medicine is a long-term project; it becomes stronger as it grows. It is the pattern for successful co-operation but it requires wise and steady leadership.

In addition to these official positions in our society, we have a number of committees made up of members with special interests and training in various fields of medicine. These committees are recognized as advisory committees to government agencies, and new ones are frequently added. Three such committees serve the State Department of Health in addition to the two physician members of the Public Health Council. Two committees serve the Department of Welfare, one the Personnel Department and one the Rehabilitation Service, and so on. Often special committees are asked to do a special job, keeping constant liaison between the medical society and government departments operating in the medical field. Each year we find new ways to assist our government with trained and skillful advisory committees in formulating policies and drafting new legislation, not in argument and contention, but in wise, good citizenship. The question of political partisanship sometimes arises, and it is my opinion that organized medicine cannot afford to play party politics. It is always a dangerous position. What individuals may choose to do is quite another matter, but sooner or later it is bound to be unfortunate if a medical society becomes identified closely with any political party. Our cause is great enough and righteous enough to transcend partisanship. If we do not make it so, we are missing the point.

In giving you these thoughts on this subject, we are not unmindful of the many and great things that the Michigan State Medical Society has done. You have seen your public responsibilities and met them well, but there is much more to come; we are not through. The challenge is pressing us sharply, and the field of our endeavor must broaden. The day is here again when we must take these responsibilities in the old tradition and in the sturdy fashion of our forefathers, and realize that we are not just a band of odd little men seeking the greatest personal advantage, but that together we are a great social force in a great country and that the continuance of that greatness lies in part with us.

STOP—LOOK—LISTEN

STOP telling the patient there is nothing wrong with him but nerves— Don't say: Go home and forget it.

LOOK for the facts as the patient sees them.

LISTEN attentively to the patient's story.

* * *

The impulses of nature are not unpardonable sins. However, to do "what comes naturally" is not always socially acceptable.

* * *

In 1939 there were 6,116 hospitals in the U. S., with an average daily population of 960,000. That same year the average daily population in hospitals for nervous and mental diseases was 562,000—a mere 58 per cent of the grand total.

* * *

Emotional disorders of adult life frequently begin in childhood—watch the child for evidence of maladjustment.

* * *

Behavior problems of youth are often early signs of psychopathic trends.

* * *

Problems which seem silly or unimportant to you may be overpowerful for your patient.

* * *

Mental illness is the source of much preventable unhappiness.

MSMS Mental Hygiene Committee.

Has all the proved benefits of genuine Mother's Oats,* fortified and especially processed for earliest cereal feeding

When the world's leading manufacturer of oatmeal, after long research, develops a cereal with all the proved, whole-grain benefits of oatmeal . . . yet especially processed for infant digestion . . . you just know it's worth consideration. BABY QUAKER Instant STRAINED OATMEAL is fortified with extra vitamins and minerals; thoroughly precooked; finely strained. Nothing for mother to do but add warm milk or formula —and how babies love it!

We're telling mothers to ask you about the Mother's Oats benefits of this new baby cereal.*

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ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods and Nutrition

BABY QUAKER

INSTANT STRAINED

OATMEAL

TYPICAL ANALYSIS

Protein	15.3%
Fat	6.8%
Carbohydrate	65.1%
Fiber	1.9%
Minerals (ash)	4.7%
	Per Ounce
Calories	108
Calcium	216 mg.
Phaspharus	278 mg.
Iran	6.6 mg.
Thiamine	0.3 mg.
Ribaflavin	0.051 mg.
Niacin	0.41 mg.

Michigan Medical Service

Gordon Goodrich, Assistant Director

During the year 1946, Michigan Medical Service paid to doctors $5,106,279.90, or an average of $13,989.81 per calendar day.

Veterans' Care Program

January 15, 1947, marked the completion of the first year of the Veterans' Care Program in Michigan. Because of the necessary work involved in the setting up of machinery to enter into this Program, full production was not achieved until the late Spring of 1946. However, the case flow was increased so that at the present time, we are handling an average of 350 to 400 cases per day. During the entire year we received and processed over 60,000 authorizations from the Veterans Administration—of this number, 40,000 have been reported back by the doctors and paid in an amount totaling approximately $400,000.

Continuing in its efforts to offer the public through enrolled groups the best possible prepayment Medical-Surgical Care Plan, Michigan Medical Service, without any increase in subscription rates to subscribers, has reinstated the maternity benefits clause in the Direct Pay Surgical Certificate, increased certain fees to doctors and liberalized certain certificate provisions.

Reinstatement of Maternity Benefits, Direct Pay Certificates

In March, 1946, notice was received from Michigan Hospital Service that it intended to eliminate maternity benefits from its Direct Pay Certificates. In the Spring of 1946, in the interest of maintaining uniformity of major contract provisions as to the Surgical Benefit Certificate of M.M.S. and M.H.S.'s Hospital Service Certificate, it was agreed to delete the maternity benefit clause from the Direct Pay Certificate. Informative notices sent to Direct Pay subscribers as to the elimination of the maternity benefit clause included the statement that terminal maternity benefits would be available for a period of nine months from the effective date of the Direct Pay Certificate. The earliest possible expiration of maternity benefits would have been February 20, 1947. Michigan Medical Service, acting in the interest of its subscribers, has now reinstated maternity benefits. Notices to this effect have been sent out so that the subscribers will receive them prior to February 20, 1947. The effect of this action is that there is no lapse in maternity benefits under the Michigan Medical Service Surgical Certificate.

Fee Schedule

During the past year the fee schedule of Michigan Medical Service was increased on 44 services. The average increase was 22.25 per cent. Under the revised fee schedule, subject to the conditions of the certificate, a minimum fee of $10.00 is payable for anesthesia, whether minor or major, plus $5.00 for each additional hour or fraction thereof.

Emergency Service Clause

The emergency service clause under the certificate, reading "Emergency surgical services not requiring bed care rendered in a regularly accredited hospital by a doctor of medicine during the first twenty-four hours following accidental injury" was liberalized by Board action to include:

1. Fractures substantiated by x-rays are paid for when treatment is rendered out of the hospital within eighteen hours of an accident.
2. Emergency office service for accidental injury not to exceed $15.00 for emergency office surgery (first aid) provided service is rendered within eighten hours of the accident. The $15.00 limitation applies solely to the surgical procedures and is available in addition to any x-ray benefits that may be obtainable.

Enrollment Regulations

Enrollment regulations have been modified to permit enrollment of a dependent child living in the home of a subscriber. Michigan Medical Service will permit the addition of children, who are neither the natural children of either parent nor legally adopted, under the following circumstances:

1. The subscriber has furnished the complete support of the child for a six-month period.
2. It is the intention of the subscriber to continue to support the child until he or she reaches the age of 19.
3. The child must reside in the same domicile as the subscriber.
4. Application must be made within thirty days of the date that the child becomes eligible under the above rules. The form may be filled out and submitted during re-enrollment periods. The addition of the child will be accepted during group re-enrollments even though an application made in this manner is not made within thirty days after the child becomes eligible.

Michigan Medical Service has expanded its field facilities and extends to doctors an invitation to request a representative to call upon him at any time to answer such questions as may arise in his mind with reference to the operations of Michigan Medical Service, such requests to be directed to Michigan Medical Service, 1200 Washington Boulevard Building, Detroit 26, Michigan.

Paid to Doctors:

1940	$ 172,115.00
1941	790,733.30
1942	2,208,623.42
1943	2,876,547.90
1944	3,437,265.50
1945	4,154,422.68
1946	5,106,279.90
Total	$18,745,987.70

nontoxic

topical antibiotic

So efficacious is TYROTHRICIN that one eminent clinician comments: "For topical application, there seems little justification for the continued use of the sulfonamides. TYROTHRICIN is an excellent agent for this purpose . . ."* • Administered by instillation, irrigation, wet dressing or spray, TYROTHRICIN swiftly combats gram-positive organisms such as pneumococci, staphylococci, streptococci, diphtheria bacilli and certain anaerobic organisms causing serious infections of the skin, soft tissues, bones and cavities not connected with the blood stream. • TYROTHRICIN CONCENTRATE (*For Human Use*), Sharp & Dohme, is indicated in topical treatment of superficial indolent ulcers, abscesses of the skin and soft tissues, chronic purulent otitis media, mastoiditis, sinusitis, empyema and certain types of wound infections. • Supplied: 1-cc. ampul of concentrate, 25 mg. of TYROTHRICIN per cc., with vial containing 49 cc. of pyrogen-free, sterile, distilled water for diluting concentrate before use; also 10-cc. and 20-cc. vials of concentrate, 25 mg. of TYROTHRICIN per cc. Sharp & Dohme, Philadelphia 1, Pa.

*Int. Abst. of Surgery 83:1-12, July 1946.

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You and Your Business

SIGLER OPPOSES SOCIALIZED MEDICINE

Governor Sigler took a definite stand against socialized medicine in an address at the Hotel Book-Cadillac.

He spoke at the second annual meeting of the Michigan Foundation for Medical and Health Education.

"I am definitely opposed to socialized medicine," he said. "I don't want the State to practice medicine."

Sigler expressed confidence that the American people would not "fall for silly notions" such as socialized medicine if they would understand the facts.

"Doctors must assume the leadership and see that people understand the situation," he said.

"The folks who should determine the course of medicine are doctors, not politicians."

He proposed a radio program on which physicians could express their views on the problem.

Among other speakers was Dr. E. I. Carr of Lansing, president of the Foundation.—*Detroit Free Press,* February 3, 1947.

WELCOME, DOCTOR!

The Michigan State Medical Society is happy to welcome the following newly elected members as of February 15, 1947, from the indicated component county medical societies:

Marshall Alcorn, M.D., Bay City .... Bay-Arenac-Iosco County
Harold R. Bodine, M.D., Battle Creek ....Calhoun County
Ruth C. Carney, M.D., Battle Creek ....Calhoun County
G. Campbell Cutler, M.D., Flint .....Genesee County
Edw. N. Elmemdorf, M.D., Lansing .....Ingham County
J. R. Franck, M.D., Wakefield .....Gogebic County
Herbert J. Hazledine, M.D., Ann Arbor .... Washtenaw County
Howard P. Hoyt, M.D., Colon .....St. Joseph County
Martin Ittner, M.D., Midland .....Midland County
Oscar B. Kahn, M.D., Capac .....St. Clair County
Claude A. Ludwig, M.D., East Lansing .... Ingham County
John T. Manwaing, M.D., Traverse City .... Grand Traverse-Leelanau-Benzie County
Brooker L. Masters, M.D., Fremont ....Newaygo County
Robert S. McClintock, M.D., Charlevoix .... Northern Michigan
Ralph H. Meng, M.D., Traverse City .... Grand Traverse-Leelanau-Benzie County
Carl A. Peterson, M.D., Grayling .... Medical Society of North Central Counties
J. Mott Rawlings, M.D., Flint .....Genesee County
John Savory, M.D., Bay City ....Bay-Arenac-Iosco County
R. G. Wetterstroem, M.D., Stambaugh .... Dickinson-Iron County

RESIDENCY IN NEUROPSYCHIATRY

The Southwestern Medical Foundation, in cooperation with the Veterans Administration, is offering a three-year residency in neuropsychiatry. Two years of this are divided into eight-month rotation periods between the Dallas area and the VA hospital at McKinney and Waco, Texas. The third year is elective, and investigative work is included. Approximately one-half of the required time covers psychosomatic medicine and mental hygiene work, including child guidance. The other half is inpatient psychiatry. The Dean's Committee consists of Dr. Guy Witt, Dr. P. C. Talkington, and Dr. Don Morris as secretary.

For further information write the Secretary of the Dean's Subcommittee for Neuropsychiatry, Southwestern Medical College, 2211 Oak Lawn Avenue, Dallas 4, Texas.

Have You Made Your
HOTEL RESERVATIONS?

MICHIGAN STATE MEDICAL SOCIETY
82nd Annual Session
Grand Rapids, September 23-24-25-26, 1947

The reservation blank below is for your convenience in making your hotel reservations in Grand Rapids. Please send your application to J. W. Logie, M.D., Chairman of Housing Committee, c/o Pantlind Hotel, Grand Rapids, Michigan. Mailing your application now will be of material assistance in securing hotel accommodations.

As very few singles are available, registrants are requested to co-operate with the Housing Committee by sharing a room with another registrant.

J. W. Logie, M.D., Chairman, Housing Committee,
Michigan State Medical Society Annual Session,
c/o Pantlind Hotel, Grand Rapids, Michigan.
Please make hotel reservation(s) as indicated below:

.....Single Room(s)
.....Double Room(s) for.....persons
.....Twin Bedded Room(s) for....persons
Arriving September .....hour.....A.M.....P.M.
Leaving September .....hour.....A.M.....P.M.
(Names and addresses of all applicants including person making reservation).

Name	Address	City	State
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Date..... Signature.....
Address..... City.....

The JOURNAL

of the Michigan State Medical Society

Issued Monthly Under the Direction of the Council

VOLUME 46 MARCH, 1947 NUMBER 3

The Management of Strabismus

By Edmond L. Cooper, M.D.
Detroit, Michigan

The subject of strabismus is one which should be of interest not only to ophthalmologists but to pediatricians and general practitioners as well. This is known to be so since probably two-thirds of the cases of strabismus seen by ophthalmologists are referred by the family doctor or the pediatrician. It is they who see the patient first, it is to them that the parents of strabismic children are most apt to turn for first advice, and it would seem that they should be interested in giving advice backed up by an adequate understanding of the condition.

Strabismus is a condition, the management of which lies solely in the hands of the ophthalmologist, and it is not necessary for this paper to go into detail regarding it. For those who wish more detail there are books and articles in the literature, and anyone can read them. The author prefers to discuss strabismus in the light of his own experience, speaking chiefly in generalities, and confining himself to those phases of the problem which will be of interest to the general physician. The discussion will be limited to non-paralytic strabismus, and no reference will be made to vertical anomalies.

Presented at the Noon Day Study Club of the Wayne County Medical Society on March 26, 1946, at Detroit, Michigan.

A question ophthalmologists are frequently asked is, "At what age do you like to begin treatment of a child with strabismus?" The answer should always be, "As soon as the strabismus is first noticed." The earlier treatment is started the easier it is and the better are the results. A good many people have the idea that an examination of the eyes cannot be made satisfactorily until a child is old enough to read. Actually a fairly good examination can be made at the age of one year and a very satisfactory one can be made at the age of two. It is true that not much can be done before a child is a year old, but most cases of squint do not manifest themselves before then. After the age of one, however, a great deal can be done and it is not advisable to wait after that age. A child will not "outgrow" a true strabismus, and to tell the parents of a child whose eyes are crossed to "wait and see" if he will outgrow it is the worst possible advice.

There are very few young children whose co-operation cannot be obtained. In order to examine them it is necessary to gain their confidence, since nothing can be done with a frightened child. There are certain tricks which can be employed to gain their interest, and once this is done examination is easy. For example, one of the things which can be done with young children is to let them examine a doll's eyes with a flashlight. This should be done before any attempt is made to approach the child itself with the light. Several dolls can be kept in the office, and it will be found that if the child is allowed to play with the light and the doll at first, no trouble will be experienced with the child's examination later.

The causes of strabismus are complicated. Briefly, when the eyes are not straight but deviate away from parallel positions, either diverging or converging, the reason is that normal co-ordination

between the two eyes has failed to develop. Normal development requires that the two eyes work together in such a way that what is seen with the right eye and what is seen with the left eye are blended in the brain into one picture. This is called fusion.

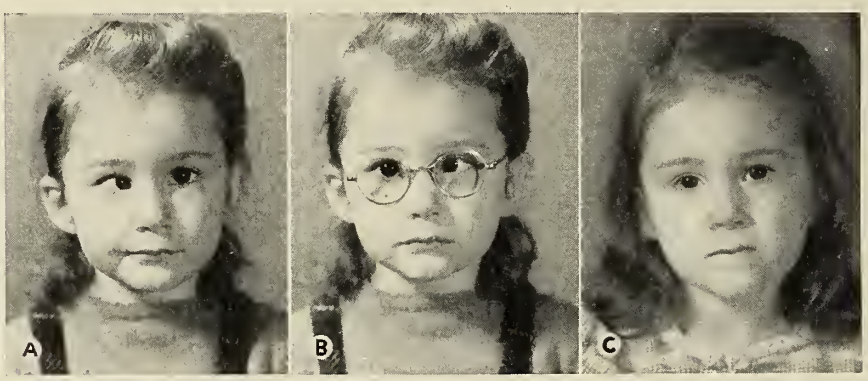

Fig. 1. K.B., a girl aged four. These illustrations demonstrate an alternating strabismus. (A) Fixation is with the left eye while the right eye converges. (B) The right eye is the fixing eye while the left eye converges. (C) Result of an operation.

Some children are born without fusion. They see well with the right eye since it is normal, and they see well with the left eye since it is also normal, but because of a congenitally defective or absent fusion sense, they cannot blend the two images together in the brain. These children therefore, if they try to see with both eyes, see double. This is a disagreeable circumstance and the children soon learn to look just with one eye and "suppress" the other. In order to make suppression easier, the eye not being used turns inward (or outward) and thus a squint develops. Other children are born with a good fusion sense, but because of other defects the fusion strengh is not enough to keep the eyes straight. A child may be very farsighted for example. In order to see clearly he has to focus his eyes strongly and the act of focussing is accompanied by the act of convergence. In most of us the fusion sense is strong enough to keep the eyes straight even when focussing, but very farsighted children have to focus so hard that the fusion sense is not strong enough to keep the eyes straight. These children, therefore, tend to develop cross eyes especially when they are focussing.

Strabismus at first may be noticed by the parents only part of the time, when the child is tired or ill or when he is looking at something at near range. At other times the fusion sense is strong enough to keep the eyes straight. But sooner or later the squint becomes permanent unless treatment is begun, and the earlier it is started the better the result.

Strabismus is often noted to develop during or after a siege of illness. Parents are frequently under the impression that their children's eyes crossed due to measles or some other childhood disease. Actually the etiological factor, the weak or insufficient fusion sense, was present prior to the illness, and the illness itself was only the precipitating factor.

Divergent strabismus most often develops in nearsighted children, in contradistinction to convergent squint which is most frequent in farsighted individuals. The mechanism of the development of the squint is essentially the same—a weak fusion sense together with refractive errors or other defects.

The examination of children with strabismus is the easiest part of the management of the condition. One of the first things to be done is to test the visual acuity. After the age of two and one-half or three, a very accurate measurement of the visual acuity can be made with the illiterate letter "E" chart. Children vary greatly in their ability to get the idea of this chart but most of them get it if they are not hurried. It is necessary to take time to explain it to them, and it must take the form of a game. This is the chart which most schools use to test vision and nearly all school children know it, but even pre-school children can be easily taught. For some children it is necessary to use a picture chart but this is less accurate. When children fail to read these charts, it is

usually because they are frightened or bashful, and they will read them at the next visit to the office if not pressed too hard the first time.

The importance of getting a record of the visual acuity is very great. As was mentioned above, children whose eyes deviate from parallelism suppress the vision in one eye to prevent seeing double. The eye which is being suppressed does not of course develop normally because it is not being used. Some children will alternate from one eye to the other, first suppressing one and then suppressing the other (Fig. 1). In such cases the visual acuity will develop normally and equally in each eye because each eye is getting its share of use. The majority of cross-eyed children, however, will use one eye exclusively and constantly suppress the other. This eye will not develop good visual acuity and, as a matter of fact, will actually lose vision from disuse so that the eye becomes partially blind. It is very important to determine whether or not this exists as early as possible since success in obtaining a good functional result depends on getting the two eyes to see equally well (Fig. 2).

After the visual acuity is measured, the angle or degree of squint is measured. This is important since improvement later can only be noted by comparing measurements. There are several methods of measuring the angle, and most of them can be done easily on very young children.

The third step in the examination is the refraction. Since farsightedness and nearsightedness are apt to play such important roles in the cause of squint, their correction is the first step in controlling the condition. A refraction can be done on any child old enough to hold his head up and look at a light. It must always be done with the eyes under the influence of cycloplegic drops since it is the only accurate way. Without drops it is impossible to determine the full amount of refractive error, especially in children.

Drops are never instilled in the child's eyes in the office, especially if it is the first visit. In the first place, the best drug to use is atropine sulphate, and this is used in the eyes for several days prior to the examination and thus is better done at home. In the second place, it is better not to put the drops in, in the office because some children find the drops unpleasant and it is better not to have that unpleasantness associated with the physician. In the third place, no young child will cooperate well if kept too long in the office, and by the time the history and visual acuity measurements have been taken, all has been done which most children will take pleasantly in one day.

Fig 2. (*above*) B.M., a girl aged sixteen. This strabismus was neglected during the years when a good functional result would have been easy. (A) The right eye turned constantly and was amblyopic, the vision in it being limited to 10/400. (B) An operation straightened the eye but did not improve the vision.

Fig. 3. (*below*) M.K., a girl aged seven. These photographs were taken on the same day a few minutes apart. (A) She had a left convergent strabismus associated with uncorrected farsightedness. (B) With glasses the eyes were straight, the patient fused well, and vision was good in both eyes.

Once the diagnosis is established treatment proceeds along three lines:

1. Correction of refractive error.
2. Exercises.
3. Surgery.

Some cases of strabismus respond readily to the correction of refractive errors alone. Others have no refractive errors and so need no glasses but will respond to exercises. Most of them need both correction of the refractive error and exercises. About half or perhaps a little more than half of all cases of strabismus will ultimately require an operation. Surgery, however, is not tried, nor even considered, until glasses and exercises have been given thorough trial.

Correction of Refractive Errors

The question is often asked how old a child needs to be before he can wear glasses. It has been the author's experience that children will wear glasses anytime after they are a year old if they really need them. One cannot expect a very young child with a small refractive error to wear glasses, since wearing them does not make much difference to him. But even a one-year-old will wear them if they materially and obviously improve his vision and his feeling of comfort. Actually more difficulty is encountered with the parents than with the children when it comes to putting glasses on them. If the circumstances are properly explained to the parents, however, they usually co-operate.

In some cases, wearing glasses will bring crossed eyes to a position of permanent parallelism within a few weeks, but usually it takes longer than this. It is not always possible to judge what the end result of wearing glasses is going to be until they have been worn faithfully and constantly for at least six months (Fig. 3). At any rate, one should not be as concerned with getting the glasses off as quickly as possible as in getting the eyes straight, no matter how long it takes. As a matter of fact, when glasses are prescribed it is because the child has a refractive error of sufficiently high degree that he would have to wear glasses anyway, cross-eyed or not.

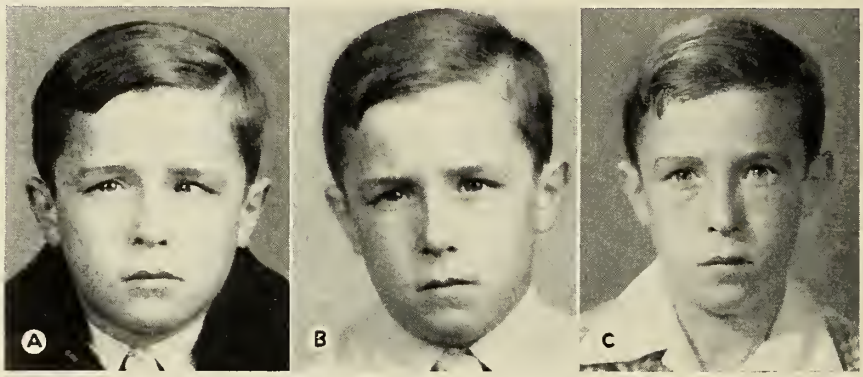

Fig. 4. K.B., a boy aged ten. (A) This boy had a left convergent strabismus with very little refractive error. (B) Improvement following an operation. (C) Further improvement after intensive fusion training.

Fig. 5. D.L., a girl aged ten. (A) This girl had a right convergent strabismus. (B) She showed no improvement by wearing proper glasses or by exercises. (C) Result of an operation.

Exercises

Two types of exercises are useful in the treatment of squint, the first to develop vision in an amblyopic eye and the second to develop and increase the amplitude of fusion.

The first type of exercises is the most important. As mentioned above, children who alternate, develop equal vision in both eyes and so do not need this type of exercises. But children who do not alternate, and this includes the majority of children with strabismus, invariably have very poor vision in the turning eye, and after necessary glasses have been prescribed no time should be lost

in beginning its development. It should be remembered that the amblyopic eye has poor vision simply because it has not been used. Therefore, the remedy is easy. The good, or fixing eye, is simply covered with a patch and thus the child is forced to use his amblyopic eye.

The length of time required to develop vision in an amblyopic eye depends on the age of the patient, the co-operation of himself and his parents, and the amount of refractive error. A very young child, under three or four years, may develop normal vision in the amblyopic eye within a month if he wears the patch and his glasses faithfully. In older children it takes longer, and at the age of ten or twelve it may take six months or a year. Nevertheless, persistence and patience will prove effective, and the end justifies the effort.

It is not possible to obtain the desired result by wearing the patch over the good eye just part of the time; the occlusion must be constant, day and night, to be effective. In addition to wearing the patch, older children may be given drawing and tracing exercises to do at home. This keeps them interested in the proceedings. While wearing it, the child should be encouraged to go ahead with his usual activities. School children should not be permitted to remain away from school simply because they are using a "poor" eye. Even though they cannot see well in school they should go and try to see, since this is what causes the vision to improve.

After the vision in the amblyopic eye has improved to normal, the patch may be abandoned but the vision must be carefully watched. The patch is re-applied if the vision starts to fail again.

The second type of exercises—to develop the fusion sense—requires more patience and skill on the part of both the patient and the doctor. Most children do not respond to fusion training until the age of five or after. It requires some intelligence and some children are never apt pupils.

The art of fusion training is one which has developed greatly in recent years until it has practically become a specialty in itself. Most ophthalmologists who are really interested in the proper treatment of squint find it more convenient to employ a trained technician to do this work. To do it properly requires more time than most can give, and an adequately trained and interested technician can do much better.

This type of training in addition to requiring an intelligent patient and a trained technician also requires certain elaborate equipment. The principle of the training however is simply this:

In order to blend the images from each eye together in the brain, it is necessary to use both

Fig. 6. (*above*) H.R., a boy aged four. These photographs illustrate the result of an operation in a case in which neither glasses nor exercises were of value in improving the strabismus.

Fig. 7. (*below*) J.D., a woman aged thirty-three. This patient had a divergent strabismus which had gone untreated for thirty-three years. (A) Glasses had no effect on the squint. (B) Result of an operation.

eyes together. Strabismus patients do not do this; they have learned to suppress one eye in order not to see double. The first step in fusion training therefore is to teach the patient to see double. Once the patient can recognize two images at once, and learn to cease suppressing and see double at will, he can then be taught to bring those two images closer and closer together until he learns to fuse them. There are degrees of fusion, and by practice some patients learn a fairly high degree (Fig. 4).

If the fusion develops fairly well, it is sometimes possible to teach children to hold the eyes straight even with their glasses off, so that the result of the exercises is not only to straighten the eyes but to teach the patient parallelism, without glasses. These cases are unusual though, and it is not meant to convey the impression that fusion

training is a "throw away your glasses" program. Nothing is farther from the truth.

Surgery

In at least half of all cases of strabismus, neither correction of the refractive error nor fusion training is sufficient to straighten the eyes. Such cases may be operated upon (Figs. 5, 6 and 7). The decision as to what operation should be done and its technique is best left up to the ophthalmologist and has no proper place in this paper. However, there are a few things about the surgery which are interesting to everyone.

There is no particular age at which operation is best performed. In the author's opinion, operation for strabismus should be advised as soon as it is definitely apparent that neither glasses nor exercises are going to straighten the eyes. This may be at any age but it is not usually before four years. When possible, it is desirable to have the eyes straightened before school age, and on occasion parents may be told that if a child's eyes are not straightened by the time he enters school, it is because he has been neglected somewhere along the line. The older the child is when first seen the more apt he is to require an operation, because the bad habits his eyes have gotten into are harder to break.

The operations themselves are not mechanically difficult. They can be done under local anesthesia on some children as young as twelve years of age. They require a hospital stay of four to seven days. Usually only one eye is operated upon at a time and it is frequently necessary to do the other eye later. This accounts for most of the "reoperations" one hears about.

MICHIGAN RULING

An attempt to unionize Edward W. Sparrow Hospital of Lansing, Michigan, which began with a partial strike last September 14, has led to a state attorney general's ruling that under Michigan law the hospital need not bargain with a union.

The Amalgamated Workers Union, C.I.O., had petitioned the State Labor Mediation Board for certification as bargaining agent. A governor's commission, as specified by the law, considered this request and decided that the hospital should permit an election among employes. The hospital's board declined to accept this counsel. The union asked the attorney general to apply the state's police powers. Last November 25 the attorney general ruled that Michigan law does not authorize the use of police powers for this purpose.

NOTE: Ten of the forty-eight states have their own laws to regulate collective bargaining. During the last three months, charitable hospitals in three of these have just been ruled outside the jurisdiction of state labor agencies. In addition to Massachusetts and Michigan reported above, see November *Hospitals*, Page 106, for details on a Rhode Island test case.—*Hospitals*, January, 1947.

Hypertensive Heart Disease

By Francis D. Murphy, M.D.
Milwaukee, Wisconsin

THERE IS NO unanimity of opinion concerning the etiology and pathogenesis of essential hypertension; and hypertensive heart disease, its chief complication, is almost as puzzling. While heart disease is not the only complication of hypertension, it is recognized as the most common one. Although brilliant research work[5] has resulted in the production of high blood pressure in animals, this must not be construed to mean that hypertensive disease has been reproduced. Hypertension itself is merely a symptom of the disease, but a symptom which has been studied thoroughly, experimentally and clinically, and whose significance is widely known. However, this is not true of hypertensive diseases. Questions concerning the cause of arteriosclerosis and the relationship it bears to hypertension remain largely unanswered. Hypertensive diseases may be classified into those of the heart, the brain, and the kidneys, but any or all of the essential organs of the body may become involved in this morbid process. Consequently, hypertension does not always fall easily into the domain of any one specialist.

Disorders of this kind do not come and go quickly but develop insidiously and often cripple the patient in the period of life of greatest usefulness to himself, his family, and the community. For most complete knowledge of hypertensive diseases, information must be obtained from those who observe the patient from the onset to the end of the disorder, and who know the patient, his personal habits, behavior, and even his ancestors. Failure to recognize the importance of the natural history of this disease has hampered our understanding of it. A study of the natural history of any disease, which includes the mode of onset and the subsequent course of the disorder to death or survival of the patient, constitutes the classical

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method of approach. These observations can be obtained from the family physician since he is the only one who is in a position to gather such information. Probably he should be called upon for his contributions more frequently.

For the purpose of this paper the subject will be taken up in the following manner: (1) The Hypertension Itself, (2) Cardiac Changes in Hypertension, (3) Heart Before Failure Sets in, (4) Heart Failure, and (5) Treatment of Congestive Heart Failure.

The Hypertension Itself

Hypertension itself may be roughly classed as primary or essential hypertension and secondary hypertension. Nephritis, pyelonephritis, adrenal growth, pituitary tumors and endocrine disturbances may cause hypertension. In a critical study of patients with essential hypertension, many were found not essential at all but secondary to one of these other causes. In the early stages of essential hypertension the patient is symptomless, and the heightened blood pressure is the only abnormality. Later the heart enlarges, the arteries harden, and the complications of hypertension develop. The term "essential hypertension" is used to embrace both the so-called benign and the malignant forms. In the benign form, the patient usually develops symptoms in the forties or early fifties, after having had an elevated blood pressure for five to ten or even fifteen years. Headaches, shortness of breath, chest pain, visual disturbance, and a feeling of malaise, may cause the individual to seek medical advice. In the benign form, the disease runs a slow, placid, calm course and terminates usually in heart failure, stroke, or uremia years after the onset of hypertension.

There is another form of hypertension known as the malignant type which is not a separate and distinct disease but is merely a phase of essential hypertension. It differs from the benign form only in degree of severity, speed of progress and ultimate outcome. Arteriosclerosis is the chief pathological change in both the malignant and benign forms, and the renal arteries and arterioles are mainly involved. However, the malignant type differs in that the arteriosclerotic process is more widespread and invades the smallest arteries and arterioles. Malignant hypertension is distinguished by necrotic lesions scattered throughout the arterioles of the kidney. Histologically the difference between benign and malignant hypertension is one of degree, not of kind.

The origin and pathogenesis of high blood pressure have been the source of considerable speculation and investigation since the days of Bright. Even this year, at a special conference[15] called for the purpose of reporting the recent advances in experimental work on hypertension, there was no generally accepted opinion on these problems. It was concluded that in the present state of our knowledge, it would be hazardous to advance the kidney as more than one contributor to this disorder which is constitutional, involving, in addition to the kidneys, the vascular bed and cerebral centers. It was generally recognized that the cause of high blood pressure is unknown and that probably the kidney plays only one important part in the development of hypertension.

The role of the kidneys in the production of hypertension is a variable one. Volhard[18] (1942) mentions that the Chinese physician Choun-You-J., who lived 200 years B. C., gave the following pulse rule: "When the pulse upon deep pressing is very firm and upon superficial palpation very tight, then the disease has its seat in the kidney." Opinions have shifted from one extreme to the other. Earlier writers[4,11,17] believed kidney disease was the principal cause of increased blood pressure and nonvalvular heart disease, while later others viewed renal disturbances merely as an end result with little or nothing to do with the genesis of hypertension and cardiac hypertrophy. In Bright's[4] day and for fifty years thereafter, hypertension was believed to be caused by kidney disease. Then followed a period of about fifty years in which the kidney was assumed to have little or no part in the etiology of hypertension. Now the pendulum has swung back and the kidney once more is looked upon as a chief offender in the causation of hypertension. A review of the opinions of those who came immediately after Bright shows that the kidney was thought to be the primary disease and that the increased blood pressure and associated phenomena were consequences. The trend away from the kidneys began when Gull and Sutton[8] and Mahomed[12] published their classical papers describing the minute changes in the smaller arteries and arterioles. For nearly fifty years following the work of Gull and Sutton,[8] the most advanced authorities on the subject sought to establish their belief that the kidney disturbance was not an important factor but merely a small part of the dis-

TABLE I. FREQUENCY OF CARDIAC HYPERTROPHY AT DIFFERENT SYSTOLIC BLOOD PRESSURES IN THE FOLLOW-UP EXAMINATIONS.*

Blood Pressure Groups	Number of Patients with Dilated Hearts	Number of Patients In Blood Pressure Groups (not all x-ray examined)	Frequency of Cardiac Hypertrophy
140–159 mm.	52	136	31.2%
160–179	78	187	41.7
180–199	55	124	44.3
200–219	50	96	52.1
220–239	28	52	54.0
240	31	48	65.0

*Bechgaard, P.: Arterial hypertension; a follow-up study of one thousand hypertonics. Acta Medica Scandinavica, Supplementum CLXXII, p. 114, 1946.

ease, and that the sequence of events was hypertension, arteriosclerosis, cardiac failure, and finally heart failure, apoplexy or uremia.

Clifford Albutt,[1] Janeway,[10] Volhard and Fahr[19] were chiefly responsible for our modern concept of essential hypertension, a condition featured clinically by high blood pressure without inflammatory or obstructive disease of the kidneys. Cardiac hypertrophy, arteriosclerosis and arteriolosclerosis are considered characteristic features of the disease. In 1934 Goldblatt's[6] work unexpectedly put an end to the second period of the story of hypertension. With a special clamp applied to the main renal artery of dogs, thereby rendering the kidneys ischemic, Goldblatt[6] produced hypertension experimentally. The modern conception of the mechanism of the pathogenesis of hypertension has been given by Page[16] as follows: The ischemic kidney liberates a substance, renin, as a result of a change in the blood supply. Renin becomes attached to an activator substance in the blood stream. The combination of renin plus renin activator in the blood results in formation of angiotonin which causes the constriction of arterioles and produces hypertension. While this theory is not accepted by everyone, it is a working hypothesis which explains some of the phases of hypertension fairly adequately.

The significance of the height of the blood pressure itself has always been of great concern, but to base the prognosis in the individual case on the height of the blood pressure is a mistake, as some patients with excessive high blood pressure may live on for years with no inconvenience. Bechgaard[2] reports a case of fifteen years duration without even cardiac hypertrophy, and points out that some patients with severe hypertension (200/120) may live for years without discomfort. The correlation of the height of blood pressure to heart disease is shown here in Table I. However, when a large series of cases is considered, the character of the problem changes, since the higher the blood pressure the worse the outlook. May[13] (1925) showed that the mortality rate from hypertension strongly increases with the elevation of the blood pressure. Fluctuations of blood pressure are common, and a patient may have benign hypertension in which one day of excessive hypertension is followed the next day by a fairly normal pressure. The condition of the heart, emotional strain, and changes in peripheral resistance have an important effect upon the height of the blood pressure. The cause of the high blood pressure, or rather the factors which enter into the cause of high blood pressure, may wax and wane. It is a bad sign, however, when a blood pressure becomes fixed at a high level, above 220 systolic and over 130 diastolic, and remains persistently at this high level without much fluctuation. Janeway,[10] who named the disorder hypertensive cardiovascular disease, stated that the study of the height of the blood pressure had been the most disappointing part of his work. Fluctuations may to a large extent be equalized when large series of cases are studied. Janeway[10] also warned against giving out a bad prognosis based on the height of the blood pressure.

The behavior of high blood pressure when heart failure is impending or present has always been a subject of interest. The blood pressure may fall to a low or to a normal level when the heart fails. At the beginning of failure, the blood pressure may become elevated above the usual level, but ordinarily it falls to a much lower figure within a short time. The systolic pressure falls more rapidly than the disastolic, but usually the entire pressure picture is reduced. It is not uncommon for the diastolic pressure to persist at a high level when the systolic is falling. This situation calls for a poor prognosis. When, during the course of an acute attack of pulmonary edema and heart failure, the blood pressure falls abruptly to a figure below normal, chances are that this is a case of something other than myocardial insufficiency. It is probable that there is an acute myocardial infarction due to coronary occlusion.

The presence of hypertension requires a few simple examinations: (1) Blood pressure determination. As pointed out above, the presence of marked fluctuations indicates that the blood pressure has not become fixed and that probably the

hypertension is more functional than organic for the time being. (2) Study of the cardiovascular system is also of first importance, since heart failure and heart disease are the commonest complications of hypertension. (3) While only a comparatively few cases have kidney failure and die of uremia, the study of the kidney in hypertension yields significant information for prognosis and treatment. (4) Ophthalmoscopic examination reveals the condition of the arterioles in the retina. The study of the eyegrounds is a study of the blood vessels of the brain, as blood vessels in the eyeground originate directly from the brain itself and probably show the same changes as the brain. Furthermore, clinical observation with the ophthalmoscope has proved the old dictum, that the eyeground is a mirror of the kidney. When so-called albuminuric retinitis sets in, the kidney is usually badly damaged, but the albuminuria has nothing to do with the damage in the eyegrounds.

TABLE II. DEATHS FROM DISEASES OF THE CIRCULATORY SYSTEM
United States 1941, 1942, 1943
Bureau of Census, Department of Commerce

Cause of Death	Number of Deaths			Rate per 100,000 Population		
	1941	1942	1943	1941	1942	1943
Hypertensive cardiovascular Disease	175,593	178,037	194,535	132.0	133.1	145.2
Acute myocarditis (except rheumatism)	3,934	4,069	4,184	3.0	3.0	3.1
Myocarditis (not specified as acute, chronic or rheumatic under 45 years of age)	679	689	711	0.5	0.5	0.5
Chronic myocarditis and myocardial degeneration (specified as rheumatic)	1,351	1,094	1,177	1.0	0.8	0.9
Other myocarditis (not specified as acute, chronic or rheumatic)	17,630	18,055	20,457	13.2	13.5	15.3
Arteriosclerosis (except coronary or renal sclerosis)	22,909	24,342	27,216	17.2	18.2	20.3
High blood pressure (idiopathic)	1,569	1,691	1,829	1.2	1.3	1.4
Arteriosclerotic kidney	65,886	63,776	65,387	49.5	47.7	48.8

TABLE III. CAUSE OF DEATH OF PATIENTS WITH HYPERTENSIVE DISEASE AS REPORTED BY VARIOUS AUTHORS.*

Cause of Death	Murphy et al.		White		Bell and Clawson		Authors	
	Number	Per Cent	Number	Per Cent	Number	Per Cent	Number	Per Cent
Congestive heart failure	171	56.4	53	53.0	187	44.5	56	49.6
Coronary thrombosis and sudden death	....	....	31	31.0	67	15.9	22	19.5
Cerebral vascular accident	45	14.9	6	6.0	81	19.5	17	15.0
Uremia	23	7.6	5	5.0	36	8.5	4	3.5
Other causes	64	21.1	5	5.0	49	11.6	14	12.4
Total	303		100		420		113	

*Goldring, W., and Chasis, H.: Hypertension and Hypertensive Disease. P. 24. New York: The Commonwealth Fund, 1944.

Cardiac Changes in Hypertension

Every patient with high blood pressure is in imminent danger of developing hypertensive heart disease. A review (Table II) of the reports from the Bureau of Census for the years 1941 to 1943 inclusive shows the vital importance of hypertensive heart disease as a cause of death. Herxheimer and Schulz[9] studied 394 cases of essential hypertension at autopsy and found 384 (97.5 per cent) had cardiac hypertrophy. Of 420 cases studied by Bell and Clawson[3] 187 (44.5 per cent) had heart failure. In an analysis of 475 autopsied cases of essential hypertension by my associates and myself,[14] 252 (53.05 per cent) died of heart failure, fifty-four (11.3 per cent) of renal failure, sixty-four (13.49 per cent) of apoplexy, forty-eight (10.10 per cent) of infection, twenty-nine (6.10 per cent) of malignant tumor, and twenty-eight (5.89 per cent) of miscellaneous causes. The comparative figures given by Goldring and Chasis[7] are shown in Table III.

Hypertensive heart disease may display itself as angina pectoris, coronary insufficiency, coronary occlusion, or congestive heart failure. In all cases, however, there exists a disproportion between the blood supply and the increased heart muscle mass which eventually results in myocardial insufficiency.

Excessive myocardial hypertrophy, auricular fibrillation or flutter, or advancing coronary occlusion may be the precipitating factors in causing the heart to fail. In most cases there is more than one factor which plays an important part.

Hypertrophy of the left ventricle is the first recognizable sign of the effect of high blood pressure upon the heart. At the beginning, hypertrophy of the heart is of the concentric type in which the left ventricular wall thickens at the expense of the left ventricular chamber. Since the transverse diameter is not increased, the clinical recognition of this is difficult, but the thickening may be suspected by observation of the rounding and blunting and elevation of the cardiac apex.

How long a patient will live with high blood pressure before the heart or some other essential organ breaks down depends to a large extent upon the condition of the arteries. The relationship of high blood pressure to arteriosclerosis is not entirely clear. Some physicians believe the arteriosclerosis is aggravated by the hypertension, but others think the reverse is true. When diastolic pressure rises to a high point, e.g., 130 mm. of pressure, and remains persistently at that high elevation, the onset of heart failure usually is not long deferred.

The Heart Before Failure Sets In

The heart in hypertension is working under a handicap: it is being called upon to do more work at a time when its blood supply is diminished due to coronary arteriosclerosis. Enlargement of the heart, which is the cardinal evidence of heart disease, is the result of hypertrophy of the heart muscle and of dilatation. As the hypertension increases the work of the heart muscle, the muscle fibers elongate and then hypertrophy. The enlarged heart muscle fiber soon outgrows the blood supply from its individual capillary. As times goes on, the heart muscle fiber becomes exhausted due to the excessive strain and the retarded blood supply. Eventually the heart muscle fiber gives way and is replaced by connective tissue.

A close relationship exists between coronary arteriosclerosis and high blood pressure, but the nature of this association is unsettled. Usually the patient with hypertensive heart disease suffers little or no inconvenience before the heart begins to fail. Although the heart is enlarged and the patient may tire more readily than usual, the ability of the heart to withstand its strain is amazing. During this period before the onset of failure, much may be done to defer the day when heart failure will inevitably occur. At this time the patient appears quite normal and requires a minimal amount of treatment, but close consideration must be given his living conditions, his occupation, and his personal habits. Although little can be done to prevent cerebral accidents and renal complications, fortunately, a great deal can be achieved in slowing down the progress of the cardiac disease. More damage than good sometimes results from ill-considered advice. Since these individuals usually feel well, one must avoid shocking them by citing the dreadful complications which may or may not occur. There is always a psychic as well as a somatic element in hypertensive diseases. It is well to assess carefully the patient's emotional strains and other phases of his life which may be influential in keeping his blood pressure high. One should learn from the patient by carefully conducted conversation whether his living conditions at home and at work are satisfactory. Occasionally simple situations which could easily be corrected may cause anxiety or emotional upsets. The occupation should be inquired into, but it is unwise to ask him to give up his present work for a so-called easier job as the change may cause more disturbance than the unfavorable condition in the present position. Then there is an occasional patient who is striving for success in a field of work entirely unsuited to him. If this situation can be recognized early enough and corrected without too much disturbance, the blood pressure often will fall to normal.

It is surprising how often the patient's personal habits aggravate the hypertension and weaken the heart which has begun to hypertrophy. Some patients obtain too little rest at night and should be warned to take as much as nine to ten hours in bed. It is a good thing to have the patient rest on a lounge an hour or so in the middle of the day. The heart is greatly relieved by having the patient recline and rest in this fashion. The amount of work thrown upon the heart is reduced 50 per cent or more when the patient is reclining. The old axiom that rest is fuel for the engine is nowhere more applicable than in hypertensive heart disease before the heart has begun to fail.

Other habits must also be considered. The diet often requires regulation. Probably the important factor here is a reduction in the amount of food

intake. It is a common thing for a patient in the forties and fifties to consume as much food or more than at an earlier period of life when he could metabolize the food with greater ease. A low protein diet containing a high alkaline ash may be effective in moderating the blood pressure.

Finally, the use and abuse of nicotine and alcohol must be considered. There is little question about the advice to be given concerning the use of tobacco. A patient with hypertension and beginning cardiac hypertrophy should stop the use of tobacco immediately and entirely. Whatever experimental work has shown, clinical experience convinces one that patients feel better and progress more satisfactorily if they discontinue the use of tobacco. There is more diversity of opinion regarding the use af alcohol. Apparently if a patient has been accustomed to use alcohol in moderation, it may not be harmful to continue in moderation. In some older individuals, a radical change in this habit may cause a great deal of discomfort. However, it is probably true that most patients suffering with hypertensive heart disease will be much better off if they give up alcohol as well as nicotine.

Cardiac irregularities, such as auricular fibrillation, flutter, and ectopic beats, may develop and hasten the day of oncoming heart failure. When a patient with a hypertensive heart develops angina pectoris, the color of the whole picture changes. The presence of angina pectoris indicates a rapidly approaching myocardial insufficiency. Congestive failure may become interwoven with coronary occlusion and myocardial infarction.

Little need be added in a discussion of drugs and other therapy in the treatment of hypertensive heart disease before failure sets in. The vasodepressors such as the nitrites are of little value and sometimes give more distress than relief. The use of potassium thiocyanate has been lavishly praised by some and as roundly condemned by others. Personal experience with this drug indicates that in over one-half of the cases potassium thiocyanate is well tolerated and satisfactory results are achieved. When using this drug, however, a careful checkup on the drug level in the blood must be made at frequent intervals. More recently Vitamin E has been recommended.

This is not the place for a complete discussion of the surgical treatment of hypertension, yet something should be said concerning it, as many patients with hypertension inquire about the advisability of sympathectomy. The value of splanchnicectomy or sympathectomy in reducing the blood pressure before heart failure, kidney failure, or cerebral accidents occur, has not been entirely determined. In my opinion it will take some years of careful postoperative observation before the exact place of sympathectomy is known. Personal experience with the operation has given the impression that when the systolic and diastolic pressures are excessively high and when there still is elasticity and resiliency remaining in the vascular system, sympathectomy may be a valuable measure to defer the complications of hypertension.

The electrocardiographic changes are variable, as there are different stages of cardiac involvement in most cases. In short, the following changes are usually found: There is a left ventricular preponderance or left axis deviation as a result of left ventricular enlargement. This finding is of no particular clinical significance as it occurs in other types of heart disease. A bundle-branch block, i.e., an increase in the width of the QRS, indicating intraventricular trouble, is commonly found. The T-waves may be inverted in Leads I or II, or alterations in the ventricular complex, which follow narrowing of the coronary arteries, may be present. The changes in the electrocardiogram which are the result of left ventricular strain must not be confused with the inversion of the T-waves that accompanies actual coronary occlusion. In left ventricular strain without coronary occlusion the take-off of the ST segment usually occurs at the isoelectric level. While with myocardial damage from coronary occlusion there is an elevation or depression at the point of takeoff of the segment, the left ventricular strain and the electrocardiographic tracings are produced by the hypertension and not by the coronary occlusion. This is indicated by the fact that after sympathectomy and subsequent relief of hypertension and left ventricular strain, the T-waves become upright rather promptly.

Heart Failure

A careful history will reveal whether the patient has had some uncomfortable sensations in the chest, such as tightening or anginal pain, or whether he is awakened at night with a feeling of suffocation. These are the early evidences of beginning heart failure. Once heart failure in hypertension has set in, it is difficult to retrieve the lost reserve energy of the heart muscle. As the left ventricle bears the brunt of the blow in

hypertension, it is this chamber which usually fails first. The early symptoms of left ventricular failure consist of dyspnea on exertion which previously had not occurred; in the morning there may be an excessive cough, due to a mild pulmonary edema, which clears up after the patient rises. Then follows the characteristic feature of left ventricular failure: nocturnal paroxysmal dyspnea. This episode may come on without warning and strike the patient while he is in bed at night. He jumps out of bed and rushes to an open window to obtain air. This attack lasts for a few minutes at first, but is a very alarming incident and the patient does not forget it readily.

Examination may show that the heart rate is slow and normal, but careful auscultation may reveal a gallop rhythm. This rhythm is characterized by three beats instead of two. The gallop sound is easy to recognize but is often overlooked. The third sound occurs immediately before the systolic beat, but it is not a part of the systolic phase. Sometimes the gallop rhythm lasts for only a brief period, but when it is recognized, it is final evidence that the heart is beginning to weaken under the strain of the hypertension. Further examination may reveal a systolic mitral murmur. This is often impressive because on former examinations no such murmur was found. This murmur is evidence of a dilating heart and indicates that the mitral ring has become so dilated that mitral insufficiency of a relative nature exists. This murmur may last a few days, and as the heart picks up its reserve force, it may disappear.

Once the left ventricle has failed, the patient's future is full of uncertainty. When treatment is instituted at the beginning of left ventricular failure, one is often astounded by the speed with which recovery occurs. The recovery, however, is more apparent than real, and within a short period of a few months, the same old story repeats itself. The episodes of left ventricular failure become more prolonged and finally the right ventricle begins to fail also. The result is complete heart failure from which the patient does not recover.

Treatment of Left Ventricular Failure

Failure of the left ventricle is followed in due course of time by right ventricular failure. These types comprise congestive heart failure, which is the terminal event in most cases of hypertensive heart disease. The treatment consists principally of rest, diet, digitalis, and the diuretics. Oxygen may be required, and aminophylline given intravenously or orally may be a helpful adjunct. Absolute rest in bed is required when congestive failure begins. Sitting in a semireclining position in bed is often more comfortable for the patient. Sometimes it may be advisable to allow the patient up in an armchair rather than enforcing absolute bed rest.

Dilaudid, grains 1/20 (3 mg.), or pantopon, grains ⅓ (20 mg.), are usually much gentler than morphine grains ¼ (16 mg.), and are to be used especially to secure proper rest at night. They may also be used to control episodes of pulmonary edema at any time. Phenobarbital, nembutal, seconal, or any of the other barbiturates may be used as tolerated for securing rest. Occasionally the bromide preparations are better tolerated by older people than any other sedative.

Diet is of great importance in the management of patients with left ventricular failure. Food intake must be limited to about 1,500 calories a day. Salt is restricted to a minimal quantity, as there is difficulty in excretion of salt, and retention of sodium in the tissues results in withholding water and in the presence of edema. One way of restricting salt intake to about two grams a day is to place the patient on a Karrell diet which contains one quart of milk each day. This may be carried on for two or three days. In the presence of edema in heart failure, an acid-ash diet is recommended.

Formerly it was customary to restrict fluids in heart failure, but this routine has been replaced by one which calls for giving fluids *ad libitum*. According to the modern view, the quantity of fluids taken is inconsequential, but salt must be restricted to less than 2.2 grams daily.

The use of digitalis is an important phase of treatment. The choice of the digitalis preparation has always presented difficulty, and at the present time, it is even more confusing because of the introduction of the new and purified glucosides of digitalis. The preparations of whole leaf digitalis are more familiar as tinctures, tablets, powders, and suppositories, which contain not only a certain amount of the active pure glucoside but some of the other glucosides of the digitalis leaf which have no specific action upon the heart. This made it necessary to standardize the digitalis made of whole leaf so each dose would have practically the same action. The cat unit, which cor-

responds to approximately 0.1 gram or 1.5 grains of digitalis leaf, is taken as the standard dose of these older preparations.

The purified glucoside include digitoxin and gitalin which are derived from digitalis purpurea. From digitalis lanata there is digilanid, cedilanid and digoxin. A close relationship exists between the pure glucosides of digitalis purpurea and digitalis lanata, but for all practical purposes, digitalization may be achieved by using any one of the purified glucosides or by using any one of the standardized galenical preparations. However, the newer preparations have certain advantages which must be taken into account when selecting a drug: absorption of the drug, potency of the preparation, speed and duration of action, and rate of excretion. The purified glucosides are more completely and more rapidly absorbed than the other preparations, and there is less tendency for nausea and vomiting to develop. The potency of the glucosides is invariable, while in the older preparations one may contain far more of the active principles than another, all things being equal. The speed of action and the duration of effect are fairly constant in the purer preparations, as also is the rate of excretion.

Nevertheless, one factor must always be taken into consideration: the individual patient receiving digitalis may not respond with the preparation of an experimental analysis and may be affected differently by various compounds. Therefore, the old rule is a good one: know well all that you can about digitalis but become thoroughly familiar with one preparation and continue using it.

Diuretics are indicated in left ventricular heart failure even though peripheral edema does not occur. The presence of pulmonary edema with dyspnea is reason enough for using diuretics. The chief preparations for diuresis are the organic mercurial compounds such as mercupurin, salyrgen, with theophylline and mercuhydrin. The use of these compounds results in the excretion of salt and water. They are best given intravenously, since intramuscular injections cause irritation. The amount of the mercurial to be given depends on the case. As a rule 2 c.c. are given daily for two or three days, and then a dose may be given every other day until the desired results are achieved. Thereafter it may be well to give an injection occasionally to keep the patient edema free. Oral tablets of the mercurial diuretics often cause gastrointestinal irritation, but the use of rectal suppositories is a fairly satisfactory procedure in many cases. While some instances of toxic reactions to the mercurial compounds have been reported, these are unusually rare when one considers the huge amount of these substances given every day.

Summary

1. An adequate understanding of hypertensive heart disease requires more knowledge of hypertension and arteriosclerosis than we possess at the present time. There is as yet no unanimity of opinion regarding the etiology and pathology of hypertension. A vast amount of information about this disease may be obtained from a study of its natural history. This is best accomplished by the family physician, as it is he alone who is in a position to furnish this sort of data.

2. The role of the kidneys in the genesis of high blood pressure is discussed, and the various theories of hypertension are considered. A simple classification of hypertension is given, and there is a discussion of the benign and malignant forms.

3. The effect of high blood pressure upon the heart is reviewed, and the role of hypertension and arteriosclerosis in hypertensive diseases is taken up respectively.

4. Observations upon the clinical features and data from autopsies of 475 cases of hypertensive heart disease are discussed, and the chief points of interest are given in the tables.

5. Although the mechanisms at work are the same before as after the onset of heart failure, there are differences in the clinical course, reactions of patients, and responses to treatment.

6. Heart failure of the left ventricular type and congestive failure as seen in the hypertensive heart are described. Suggestions are made which may aid in deferring the onset of failure.

7. Treatment of the patient with hypertension before the onset of heart failure and afterwards is considered. The value of psychosomatic approach as well as the benefits derived from diets, diuretics and digitalis are pointed out. Special attention is devoted to the saltless, acid-ash diets and to the use of the new purified glucosides of digitalis.

References

1. Albutt, C.: Diseases of the Arteries including Angina Pectoris. London: Macmillan and Co., 1:381, 1915.
2. Bechgaard, P.: Arterial hypertension, a follow-up study of one thousand hypertonics. Supplementum CLXXII, 1946.
3. Bell, E. T., and Clawson, B. J.: Primary (essential) hypertension: A study of 420 cases. Arch. Path., 5:939, 1928.
4. Bright, R.: Cases and observations illustrative of renal disease accompanied with secretion of albuminous urine. Guy's Hosp. Rep., 1:338, 1836.

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Some Clinical Disturbances of the Endocrine Glands

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While in "the spoken word" brief reference was made to most of the endocrine glands, this written report, because of limitation of space, will include mention only of three aspects of endocrinology: the parathyroids, the thyroid and a brief discussion of hyperinsulinism.

Hyperparathyroidism

In 1926 Mandl[14] reported the first instance of hyperparathyroidism caused by an adenoma of the parathyroid glands. In 1930 Bauer, Albright and Aub[6] reported other instances. In 1934 Albright, Aub and Bauer[1] reported seventeen proved cases of this disease, most of which they had observed during a period of two years. Analysis of these cases led them to conclude that (1) hyperparathyroidism can occur without evident disease of bone, (2) involvement of the urinary tract is a more common and more important manifestation of hyperparathyroidism than involvement of the skeleton, (3) hyperparathyroidism is relatively common, and (4) it is the etiologic factor in the formation of renal calculi in an appreciable number of cases. The importance of this report was the emphasis on the fact that hyperparathyroidism is not primarily a disease involving bones As a matter of fact in sixty-seven proved cases reported by Cope,[9] classic osteitis fibrosa cystica was encountered in only a third, few osseous changes in another third and none in the remainder. If we physicians wait until the classical skeletal findings are present, we have too often waited too long to do much for the patient. Earlier diagnosis can be accomplished only by developing a high "suspicion threshold." The development of a higher threshold led to the finding by Keating and Cook[12] of twenty-four proved cases in less than two and a half years in the same institution where only fourteen cases had been reported in the preceding fourteen years.

In what cases should hyperparathyroidism be suspected? As discussed by Keating and Cook, symptoms result (1) from chemical changes in the blood and urine, (2) from secondary involvement of the urinary tract, and (3) from involvement of the skeleton. Those symptoms associated only with an elevation of the serum calcium and a reduction of inorganic phosphorus in the serum may be missed. The symptoms of hyperparathyroidism are the antithesis of parathyroid tetany; they include atony, weakness, fatigue and constipation. Anorexia, loss of weight, nausea and vomiting also are encountered. The excessive excretion of calcium and phosphorus may produce severe polyuria and polydipsia. If unrecognized, this excretion favors the formation of renal calculi in the renal pelvis or even deposition in the renal tubules. Thus urinary symptoms may be produced (1) by urinary calculi, (2) by infection and pyelonephritis, or (3) by impaired urinary function. Symptoms attributable directly or indirectly to renal calculi occurred in eighteen of the twenty-four cases.

Symptoms referable to the skeleton, when present, varied from vague or insignificant aches and pains to the disability and pain accompanying the pathologic fractures, cysts, tumors and deformities which occur in the classic bone disease of hyperparathyroidism.

The diagnosis of hyperparathyroidism at present depends on the demonstration of (1) an increase of calcium in serum, (2) a reduction of inorganic phosphorus in serum, and (3) an increased loss of calcium in the urine. The normal value of calcium in the serum is 10.0 mg. plus or minus 1.0 mg. per 100 c.c. In the past it has been felt that serum calcium readings of 12.0 mg. or more per 100 c.c. were essential for the diagnosis of hyperparathyroidism. It is now recognized that the elevation need not be more than very slight if repeated determinations prove that the slight elevation is consistent. In twelve of the twenty-four cases the serum calcium readings were less than 12.5 mg. per 100 c.c. It should be emphasized that in conditions producing an elevation of serum protein, notably multiple myeloma and sarcoidosis, there is an associated elevation of the serum calcium. Forty-five per cent of the calcium is bound to protein as calcium proteinate and is unaffected by the parathyroid hormone. It is the 55 per cent of ionic calcium which is of significance.

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Therefore, an elevation of serum calcium is significant only when the serum proteins are normal. A lowering of serum proteins has not produced difficulties in the diagnosis of hyperparathyroidism.

The normal level of inorganic phosphorus is 3.5 mg. plus or minus 0.5 mg. per 100 c.c. of serum. The average depression of the serum phosphorus is small, and considerable fluctuations may occur in the same patient from time to time. In several instances the depression of phosphorus was the best clue to the diagnosis, particularly when the value of serum calcium was equivocal.

Albright, Aub and Bauer[1] have emphasized that elevation of alkaline phosphatase is a reflection of bone disease but not of hyperparathyroidism *per se*. This is supported by Keating and Cook's observation that the phosphatase was consistently elevated only in cases of involvement of bone.

The Sulkowitch test[3] is an exceedingly simple and useful method for the rough estimation of the urinary excretion of calcium. In the absence of renal disease a low level of excretion of calcium as indicated by the Sulkowitch test in a concentrated specimen of urine effectively rules out hyperparathyroidism. A high excretion cannot be considered of significance if the patient has been on a high calcium diet. The diet used by Bauer and Aub[5] provides a low calcium intake essential for quantitative studies.

The roentgenologic diagnosis of hyperparathyroidism is of value in the later stages of this disease. Camp and Ochsner[7] have reviewed these changes, which vary from the fibrous appearance of the long bones and the miliary osteoporosis of the skull to widespread demineralization of the entire skeleton, pathologic fractures, multiple cystic regions, expanding tumors of bone and many sorts of skeletal deformities. It is this tragic picture which can be prevented by earlier diagnosis.

Earlier diagnosis can be accomplished only by suspecting the diagnosis. Every patient who has a renal calculus and particularly every patient who has multiple calculi should be strongly suspected of having hyperparathyroidism.

Thyroid

For many years thyroidectomy has been the accepted treatment for most goiters. The use of iodine for the medical treatment of some goiters and for the preoperative and postoperative treatment of others is well defined. Before discussing newer methods, it should be said that any new method must be exceptional if it is to compete with the excellent results accomplished by established methods. Where physicians and surgeons have made a team and have really studied the patient who has goiter, the results are most encouraging. The three most difficult problems are heart failure secondary to long-standing hyperthyroidism, the serious ocular disturbances sometimes seen, and the problem of the recurrence of exophthalmic goiter. Will newer treatments help with these? Or are newer treatments simply another way of caring for the goitrous patient who already is well treated by established methods?

The two newer treatments consist first in the use of chemicals and second in the use of radioactive iodine. There are many references to the use of chemotherapeutic agents, as originally described by MacKenzie and MacKenzie,[13] in the treatment of goiter. Beginning with thiourea, many drugs have been tried. Thiouracil proved to be a much better drug than thiourea, and propylthiouracil has proved less toxic than either. Space prevents a discussion of the several hypotheses as to the mode of action of these drugs. The hypothesis most commonly voiced is that they interfere with the production of the thyroid hormone, in contrast to the use of iodine which is supposed to modify the character of the hormone. This is, of course, largely a matter of conjecture. Certainly they have a vastly different effect from that of iodine on the thyroid as observed microscopically. Following iodine therapy, the thyroid of exophthalmic goiter shows a flattening of the epithelium with the deposition of colloid. Thiouracil produces a marked increase of hyperplasia, although this varies considerably and cannot be measured quantitatively. Williams[16] reported no more hyperplasia in the thyroid of patients receiving thiouracil for a year or more than in those receiving it for only a few weeks. There is no recorded instance of any carcinomatous change.

Is thiouracil a medical cure for hyperthyroidism? I am sure no one will answer the question with a flat, "Yes!" Williams[16] has reported his results following the prolonged administration of thiouracil to 100 patients. "Forty-nine subjects have now gone for intervals of from three to twenty-one months without any treatment of any type and have remained free of thyrotoxicosis as indicated by clinical examinations and estimations of the basal metabolic rate, which, in most cases, were performed every one or two months. On the

other hand, there were fifty-one patients who had a relapse of the thyrotoxicosis at intervals of from two weeks to five months after cessation of thiouracil treatment." It is a fine thing to have competent observers who will follow their patients for years. In time we shall have the answer to this question. My guess is that it will be, "Propylthiouracil, or some allied derivative, is a medical cure for some patients, but not for others."

Does thiouracil offer a distinct advantage in the preoperative preparation of exophthalmic goiter? Astwood and VanderLaan,[2] Bartels[4] and many others have made most encouraging reports. Unquestionably all workers in this field have found many patients who could not be properly prepared with iodine but who responded well to thiouracil. Its value in such instances cannot be questioned. There is, however, a difference of opinion regarding its use in the average case of exophthalmic goiter. With strong solution of iodine (Lugol's solution), the patient usually can be prepared for operation within ten to fourteen days. Thiouracil, as a rule, requires a much longer period (four to eight weeks) and has the great disadvantage of making the gland more friable and vascular. This has been overcome by giving strong solution of iodine for several weeks prior to operation while continuing administration of thiouracil.

What of the toxicity? In almost every article the author does his best to emphasize that all chemotherapeutic agents carry a certain risk. In spite of these warnings, thiouracil is sometimes administered to patients without proper supervision. Deaths have occurred with the best supervision. Propylthiouracil probably will supplant thiouracil, and other agents will be suggested for trial, but all should be used with caution. Physicians should read with care the articles[10,15,17] reporting the toxic reactions. These reactions are as varied as they are with any drug, ranging from a mild fever or cutaneous reaction to agranulocytosis. Frequent leukocyte counts are most important and observation should continue as long as the drug is used, for reactions occur late as well as early. This applies as well to thiobarbital and propylthiouracil, although recent reports indicate that propylthiouracil is the least toxic of all substances which have been submitted for trial.

In the May 11, 1946, issue of the *Journal of the American Medical Association*[8,11] are two articles dealing with the use of radioactive iodine in the treatment of hyperthyroidism. These two articles and the editorial in the same issue give all of us the opportunity of observing an entirely new treatment. Since that date the government has begun to release supplies of radioactive iodine for clinical study. Will this supplant thiouracil? Will it supplant surgical treatment? Again no answer can be given. The treatment sounds exciting, for the patient simply swallows a glass of water containing a salt of radioactive iodine and the radioactivity is limited to cells which have an affinity for iodine—which virtually limits its activity to the thyroid. Hertz and Roberts[11] reported its use in twenty-nine cases; Chapman and Evans[8] in twenty-two cases. These are not enough for conclusions, of course, and many months or years will pass before the results and the potential dangers can be evaluated.

Hyperinsulinism

It is important to define hyperinsulinism before discussing it. In this discussion the term is limited to those patients whose condition is caused by the excessive production of endogenous insulin due to a tumor or hyperplasia of the islands of Langerhans. It does *not* apply to any other type of hypoglycemia. Specifically, it does not apply to the nervous person who feels weak between meals.

Since a patient who has hyperinsulinism is producing too much insulin, his story is usually quite typical. He may be found unconscious in the morning. If he is awake he is usually confused or has a headache or some other hypoglycemic manifestation. He eats his breakfast but by the middle of the morning he must eat again. He eats at noon, at 3:00, 6:00 and 9:00 P.M. and often must eat during the night if he is to "last" until morning. With exercise he must eat more frequently. At any time when he has trouble, he is promptly relieved by the ingestion of glucose, or if unconscious he promptly responds to the intravenous administration of glucose. He never has symptoms after eating; he always has trouble when he has gone without food or has exercised, or both. Blood sugar determinations obtained when he is in trouble usually show real hypoglycemia (20, 30 or 40 mg. of glucose per 100 c.c. of blood) and he never has trouble when his blood sugar is normal. Sugar tolerance curves are unnecessary for this diagnosis; if obtained, the curve is more frankly "diabetic" in type than normal or flat.

Granted that this may be an exaggerated case, it illustrates hyperinsulinism in contrast to those unfortunate persons who wake up tired and stay tired

most of the day. Eating sometimes helps them and sometimes does not, and their weak spells may well follow a meal. Their blood sugar levels rarely go below 50 or 60 mg. per 100 c.c. of blood, although after the ingestion of glucose they sometimes are found lower. Sugar tolerance curves, by various methods, give varying results, and flat curves are often reported.

I am perfectly willing to admit that such patients have a disturbed carbohydrate metabolism but I insist that this is simply a part of their clinical picture rather than a cause of their troubles. Also, I shall continue to insist that such patients should not be listed in the literature as having hyperinsulinism. There are not many more than 100 proved cases of hyperinsulinism in the literature. For each patient who has true hyperinsulinism, there are at least a dozen with this diagnosis who do not fulfill any of the criteria.

The treatment of true hyperinsulinism is a surgical exploration. If the story is correct, the tumor should be there. One patient who had five negative explorations by three competent surgeons died several years after the last exploration and the tumor was then found buried in the head of the pancreas. All these tumors should be regarded as being malignant or premalignant.

The treatment of the nervous or constitutionally inadequate person who has "hypoglycemia" is more to the "psyche" than to the "soma." If he feels better eating frequently, let him eat. If he feels better on a high protein, low carbohydrate diet, let him have it. But above all, make certain that he understands the importance of a well-rounded life in contrast to the narrowed focus on a single symptom.

References

1. Albright, Fuller; Aub, J. C., and Bauer, Walter: Hyperparathyroidism; a common and polymorphic condition as illustrated by seventeen proved cases from one clinic. J.A.M.A., 102: 1276-1287, (Apr. 21) 1934.
2. Astwood, E. B., and Vander Laan, W. P.: Thiouracil derivatives of greater activity for the treatment of hyperthyroidism. J. Clin. Endocrinol., 5:424-430, (Dec.) 1945.
3. Barney, J. D., and Sulkowitch, H. W.: Progress in the management of urinary calculi. J. Urol., 37:746-762, (June) 1937.
4. Bartels, E. C.: Use of thiouracil in the preoperative preparation of patients with severe hyperthyroidism. Ann. Int. Med., 22:365-372, (Mar.) 1945.
5. Bauer, Walter, and Aub, J. C.: Studies of inorganic salt metabolism. I. The ward routine and methods. J. Am. Dietet. A., 3:106-115, (Sept.) 1927.
6. Bauer, Walter; Albright, Fuller, and Aub, J. C.: A case of osteitis fibrosa cystica (osteomalacia?) with evidence of hyperactivity of the parathyroid bodies. Metabolic study II. J. Clin. Investigation, 8:229-248, 1930.
7. Camp, J. D., and Ochsner, H. C.: The osseous changes in hyperparathyroidism associated with parathyroid tumor: a roentgenologic study. Radiology, 17:63-69, (July) 1931.
8. Chapman, E. M., and Evans, R. D.: The treatment of hyperparathyroidism with radioactive iodine. J.A.M.A., 131:-86-91, (May 11) 1946.
9. Cope, Oliver: Hyperparathyroidism: sixty-seven cases in ten years. J. Missouri M. A., 39:273-278, (Sept.) 1942.

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Varicose Veins

Observations on Management and Mismanagement

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THE TENDENCY FOR both the public and the medical profession to minimize the importance of varicose veins has led to much needless suffering and a feeling on the part of the average layman that the treatment of varicosities is usually unsatisfactory. A careful survey of the methods of treatment employed reveals a startling lack of concept of the basic pathologic factors underlying this condition. In spite of the fact that the literature is rich with excellent articles on the subject, it would appear that the average practitioner feels that proper treatment is standardized and there is no more to be learned. If these men were to follow up their cases for a year or two, it would soon become apparent that the results in many instances leave much to be desired. Follow-up, however, requires a certain amount of initiative because the dissatisfied patient is more apt to go elsewhere for further treatment than he is to return to the original physician. The very fact that the patient has not returned often lulls us into a false sense of security that the results have been uniformly good. This situation is more apt to obtain in a city than in a rural community.

Perhaps the greatest source of difficulty is trying to make the patient fit the treatment rather than the opposite. When high ligation of the saphenous vein was demonstrated to be effective in certain types of cases, there soon became apparent a growing tendency to apply this procedure to all cases of varicosities. Injection treatment alone had been disappointing in a high percentage of cases and ligation gave the practitioner something definite to offer. This procedure also had a certain amount of appeal because of the apparent logic of interrupting and obliterating a pathologic venous system. The very logic and simplicity, however, are probably the greatest pitfalls because of a human tendency to accept an easy solution to a

troublesome problem and not follow it further. The fact that varicose veins are so commonplace and undramatic engenders the attitude that no great amount of diagnostic acumen or special ability is required in their treatment, and yet the average practitioner will call in a specialist for the relatively simple management of a severed nerve.

Perhaps the Trendelenburg test and all the various interpretations which have been placed upon it have done more to confuse than to simplify the evaluation of varicose veins. So much has been written and so many tests proposed that it is conceivable that the physician who is exposed to all of this information feels either there is much ado about nothing, or the subject is extremely complicated and not well understood.

While it is true that the etiology of varicose veins is obscure, it is wise to accept as a working hypothesis the possibility of inherent structural weakness in the tissues composing the walls and the supporting areolar tissue. The precipitating factors which bring about the visible pathologic changes are better understood. When starting an examination of a patient with varicosities, two possible etiologic factors should be ruled out immediately: (1) dilatation due to back-pressure from a mass within the pelvis or abdomen, and (2) compensatory dilatation due to obliteration of the deep venous system. If the former situation exists, treatment should first be directed at the intra-abdominal pathologic condition; if the second condition is present, obliteration of dilated superficial channels must be undertaken with considerable caution and cannot be performed on an extensive basis. These conditions are not often found, but if they are always kept in mind, embarrassing situations can be avoided. Often a patient will present himself with numerous small rosettes of tiny vessels which may be distressing to him from a cosmetic standpoint but are never symptomatic. This type of vascular change is not truly varicose but is more closely related to telangiectasis or even hemangioma, and treatment is almost always unsatisfactory from a standpoint of injection or ligation, or both. Such cases are best handled by a dermatologist.

With the above pitfalls eliminated, the field becomes narrowed to those veins which are amenable to treatment, and this represents the big majority of cases. The extremities should be carefully studied to determine whether the greater or lesser saphenous system is involved, or in many instances both. In a few cases I have seen, involving the thigh and geniculate areas, the dilated veins were tributaries of neither saphenous system but drained directly into the deep circulation through connections with perforating branches of the profunda femoris. A thorough knowledge of the normal anatomy of the superficial veins of the lower extremity is essential to proper appreciation of the pathologic conditions involved. Any good textbook on anatomy can be referred to for an adequate survey of this subject so it will not be taken up in any detail in this discussion. The anastomoses between the various systems should be stressed, however, and their importance cannot be overestimated. It is most distressing to examine a patient several months after treatment and find that several of the major channels which supposedly had been obliterated are again widely open and bulging due to neglected anastomoses. At the level of the fosa ovalis the superficial circumflex iliac and the superficial internal pudendal branches are of some importance and should always be severed during the course of high ligation. Of far more importance in this region, however, are the internal and external superficial femoral veins which usually join the long saphenous at the lower margin of the fossa ovalis. These vessels have long tributaries which arise at the level of the knee and proceed upward, draining most of the subcutaneous tissue of the thigh. The internal superficial femoral vein has a large tributary which joins a branch from the lesser saphenous vein just before the latter perforates the popliteal fascia to join with the deep system. This represents the highest communication between the internal and external saphenous systems and is of considerable importance in cases where high ligation is to be performed. These superficial femoral branches can easily be included in high ligation if the operator will take time to look for them. The next anastomotic level between the two saphenous systems is just below the knee and from this point downward to the toes the channels of communication are multiple. These small communicating vessels rarely have valves. Enlarged anastomotic channels should be carefully sought for and divided during the early stages of treatment.

The importance of the perforating veins which proceed from the superficial to the deep venous system at various levels is well known and has been stressed many times. These veins do contain valves which normally permit the flow of blood

only from superficial to deep. Whether due to loss of tissue tone or increased intraluminal pressure, these veins will at times become dilated, separating the valve leaflets and permitting blood flow in the reverse direction. This in turn increases the pressure in that portion of the superficial system between contiguous valves and contributes to the dilation and insufficiency of these valves. The rate of blood flow in the superficial vessels becomes retarded due to the thinned out walls and increased weight of the fluid column. While the motion of venous return may be greatly slowed, it is extremely doubtful that the direction of flow is at any time from above downward. The number of perforating veins is extremely variable, but their location is easily marked by a bulging of the superficial system at the point of junction.

Another point which a review of the anatomy of the superficial veins reveals is the proximity of certain of the subcutaneous nerves to the main saphenous trunks. The internal saphenous nerve meets the internal saphenous vein just above the knee and stays in close proximity from this point downward supplying the medial aspect of the leg and the foot. The external saphenous nerve maintains fairly close proximity with the external saphenous vein along the posterior aspect of the lower half of the leg and the ankle. Either of these nerves can be easily damaged if multiple ligations are being carried out. The internal saphenous is especially liable to injury, but this can be avoided if its location is borne in mind. While severance of one of these nerves results in no serious sequelae, the resulting cutaneous numbness is often very annoying to the patient.

One of the most important steps in the successful surgical treatment of varicose veins is admission to the hospital as a bed patient the day before operation. The leg should be carefully reexamined the evening before the operation, and at this time the various levels of proper ligation should be mapped out. This is best accomplished by means of two tourniquets or two elastic bandages applied both above and below the suspected area. The leg should be studied segmentally in this manner from below upward noting the areas of bulging between the tourniquets. These areas can be marked with silver nitrate or dye, but the most satisfactory method found by the author is to scratch the areas with the point of a hypodermic needle sufficiently firmly to leave linear abrasions. Such a mark does not wash off nor does it cause damaging irritation by chemical action. The preoperative preparation should be thorough and adequate. If high ligation is anticipated, the pubic hair should be removed inasmuch as the adipose-areolar tissue in the region of the fossa ovalis becomes very easily infected. The preparation should be carried downward to at least the ankle, using soap, water, and an effective skin antiseptic, followed by enclosing the entire limb in sterile towels. Sufficient sedation should be given to insure a good night's rest. Preoperative administration of one of the barbiturates followed by a small dose of morphine will do much to allay fear and apprehension, and will make the local anesthetic much more satisfactory. If the ligations are to be multiple and extensive, it is usually wise to give the patient a light general anesthetic. Ordinarily, however, local anesthetic of 1 per cent novocaine is sufficient and has the advantage of permitting the patient to become ambulatory very soon after the operation.

Let us consider first a relatively simple case of varicosities in which the dilated vessels are limited to that area on the posteromedial aspect of the leg below the knee. Let us assume that the internal saphenous above the knee is not enlarged and presents no tortuosities, and that no large anastomotic branches with the lesser saphenous are present below the knee. This type of case is usually the result of reverse blood flow through perforating veins due to incompetent valves. Treatment does not require high saphenous ligation but is rather directed toward location and elimination of the perforating vessels. Having determined the various levels to be ligated, the procedure is carried out under local anesthesia. The main saphenous trunk should be interrupted behind the knee and the varicose branches at the points as noted above. It is extremely important to realize that simple ligation at the entrance of the perforating veins into the superficial system is not sufficient, rather a careful excision of this area and all the tributary branches should be carried out. An amazing amount of dissection can be performed through a small incision if the operator will take sufficient time to accomplish it. Injection may be carried out at the same time as ligation or may be postponed until a later date. It should be stressed that the dilated veins between the areas of excision of defective perforators will frequently thrombose spontaneously and not require injection. If injection is postponed, it will

be found that approximately one week after ligation, when healing is well under way, the exact extent of veins requiring sclerosing solution can be much more easily determined and the procedure more accurately carried out. The author has found after considerable trial and error that delayed injection is the more satisfactory method. Each patient should be tested for sensitivity to any substance which is to be used as an irritant.

Another type of case frequently encountered is similar to that just described but involves also the great saphenous system above the knee. In this instance, treatment should be commenced with high ligation of the saphenous vein at the fossa ovalis, including all the major tributaries. If the vein is not particularly tortuous, an ureteral catheter can be introduced in retrograde fashion as far down below the knee as possible and approximately 5 c.c. of sclerosing solution instilled as the catheter is slowly withdrawn. If the perforating veins are not large, this will often yield satisfactory obliteration, minimizing injections to be done at a later date. Experience will teach which cases are suited to this method. If the great saphenous is to be interrupted behind the knee, as is usually indicated, great care must be taken not to spread sclerosing solution into the tissues if retrograde injection has already been performed. Because of this danger and the tendency toward more numerous levels of ligation, the writer has gradually given up retrograde injection. After the high ligation has been accomplished, the operator then proceeds with multiple ligations at lower levels in the same manner as described in the preceding hypothetical case.

Another variation would be that in which the lesser saphenous is involved either alone or, as more often happens, in conjunction with the great saphenous system. The procedure in this case would be to obliterate the lesser system and also the greater if indicated. Perforating vessels and their telltale bulges are located and incised as before, and the main trunk of the lesser saphenous is divided as it perforates the popliteal fascia. It is important to interrupt all visible anastomotic channels between the two systems.

Every so often a patient will present himself with huge varicosities of many years duration which he suddenly decides should be corrected. The areas of bulging and dilatation are often as large as the examiner's fist, and have progressed to such an extent that the relationship with perforating vessels and anastomotic channels is lost in the huge size. Such cases present a very real problem but are surprisingly amenable to treatment if the operator will be painstaking. The patient should be warned that the treatment will require considerable operative work and probably a considerable number of follow-up injections at the office, and that certain scars will be left upon his legs. If the patient is made to understand that the treatment is prolonged and somewhat difficult but that good results can probably be expected, he will usually be most co-operative and will not expect miracles. The pathologic condition in such cases is best dealt with under general anesthesia; at least a two-hour procedure must be expected. The surgery consists of adequately long incisions over the areas of greatest bulging with very careful block dissection of the varicose mass with all of its tributaries. Because of the extreme dilatation of the varicosities and the tendency of the dilated loops to adhere to each other and to overlying skin, the dissection will be found to be very tedious. Special attention must be directed toward keeping the wound dry and carefully approximating the skin edges so as to minimize the amount of resultant scarring. Sometimes it is necessary to make as many as thirty separate incisions, including the high ligation. At the termination of the operation, wide ace bandages should be applied from toes to groin, and these should be worn for a period of one week. At the end of this time such supplementary injections as necessary may be commenced.

Too often the physician is faced with cases in which treatment is of doubtful value. He should be familiar with such conditions and with the limitations of therapy. Foremost among these is the pigmented, chronically swollen leg with or without ulceration. Frequently stasis dermatitis of extensive character is a complicating factor. Such cases require a considerable amount of conservative treatment before surgical removal of the underlying venous abnormalities can be undertaken. Swelling must first be overcome. This is best accomplished by bedrest, elevation, and mild uniform pressure. Various local applications in the form of healing and antiseptic ointments may be employed if indicated. Large doses of vitamins and attention to the patient's serum protein level are also necessary. When the swelling has been eliminated, and ulceration and dermatitis have

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Local Tonsillectomy

By Henry T. E. Munson, A.B., M.D.
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THE REMOVAL OF tonsillar tissue, after local infiltration of novocaine, is a very common procedure, but, all too often, little reference to this operation appears in our current literature. Certain observations are here presented, all data being accumulated from October, 1943, to September, 1945, during which time I removed 964 pairs of diseased faucial tonsils from Navy and Marine personnel. Some of the problems encountered should be of definite interest to the general surgeon, as well as to beginners in the field of otolaryngology.

It must be emphasized, however, that the great majority of patients in this survey were ideal candidates for a local procedure. They were practically all male Marines in the age group of eighteen to forty. They were also 100 per cent in favor of having their tonsils removed. I never insisted on a man subjecting himself to the operation. They either wholeheartedly accepted my recommendation, or were returned to their battalion surgeon for symptomatic treatment.

I do not wish to delve too deeply into the various indications and contraindications for a local tonsillectomy. No two medical men think alike on this subject. Suffice it to say that in this particular series the indications and contraindications were:

Indications:

1. History of repeated severe sore throats.
2. History of a definite peritonsillar abscess.
3. Presence of an active, chronic otitis media.
4. Prophylactic removal was done in several cases of arthritis and rheumatic fever.

Contraindications:

1. Presence of an elevated temperature.
2. Symptoms of a sore throat at the time of operation.
3. Symptoms and signs of a really acute coryza.
4. Bleeding and clotting time definitely abnormal.
5. Presence of an active rheumatic fever.
6. Presence of an untreated luetic condition.

Operations were scheduled in the outpatient clinic, two to four weeks in advance, no more than four appointments being taken for any one morning. The patient received instructions to have his blood tests done immediately (Kahn test, bleeding and clotting times routinely; complete blood counts when indicated), and then return to the hospital for admission on the afternoon prior to the operation. Operation was deferred if the patient showed any signs of acute infection at the time of admission.

Preoperative medication was rather routine but of vast importance. Food and liquids, by mouth, were not allowed six hours prior to the scheduled time of the operation. A dose of 1.5 grains of nembutal were prescribed one and one-half hours before going to the operating room, and, rarely, in the case of an anxious individual, the nembutal was also given the night before. Thirty minutes were allowed for gastrointestinal absorption of the barbiturate, and then morphine and scopolamine were administered by hypodermic injection. (This thirty-minute interval is very important.)

Doses of ¼ grain of morphine sulfate and 1/100 grain of scopolamine hydrobromide were given routinely for a robust, adult male. In the case of a slight individual or of one past fifty (none in this series), 1/6 grain of morphine combined with 1/150 grain of atropine or scopolamine was given hypodermically. Scopolamine is preferred routinely to atropine because of its hypnotic qualities, but at the two extremes of life, youth and old age, atropine is a safer drug to prescribe.

With the nembutal given at 7 A.M. and the injection of morphine and scopolamine at 7:30 A.M., the patient was wheeled to the operating room at 8:30 A.M., well sedated but still able to co-operate. The patient was placed in a sitting position, the operator being seated on a revolving stool directly in front of the patient. The posterior tongue, palatal, and pharyngeal regions were then sprayed or painted with a 10 per cent cocaine solution to deaden the otherwise annoying gag and cough reflexes. A 1 per cent novocaine solution, containing eight drops of 1:1000 adrenalin per ounce of novocaine, was injected in four different areas: (1) the anterior pillar, (2) the posterior pillar, (3) the base of the tonsil bordering the tongue, and (4) the hilar area, where the large afferent nerves and blood vessels enter the tonsil. An angular needle was used on the first three areas, whereas a straight needle was used to approach the hilus, the tonsil being firmly retracted towards the oral cavity. Between 12 and 15 c.c. of the 1 per cent novocaine-adrenalin solution were used

for each tonsil, a total of about one ounce being consumed for the bilateral anesthetic.

The tonsils were then removed by dissection and snare, a curved No. 11 knife blade being used for the incisions of both anterior and posterior pillars. A dissecting instrument with a saw-tooth edge was found to facilitate the blunt dissection, and the tonsil was completely freed anteriorly, posteriorly, and laterally. A snare was used at the lingual border, under direct vision, so that unrelated structures were never included in the snare bite.

Any apparent bleeders were then ligated by a single slipknot. There was only one patient in the entire series who required a suture with a needle. He had a persistent hemorrhage from the posterior tongue border, a most difficult region to approach with a slipknot. The adenoid region was then approached, if necessary, but only six patients in this series of 964 had enough nasopharyngeal lymphoid tissue to warrant surgical removal. Roentgen therapy was not used in this group of service personnel.

The postoperative regime consisted of (1) placing the patient flat in bed, lying on the abdomen, for a period of four to six hours, (2) prescribing morphine sulfate (1/6 grain) rather routinely two hours after operation, and, (3) ordering a liquid-to-soft diet for the first twenty-four to twenty-eight hours. (Liquids were not taken by mouth until four hours after operation.)

The patient usually shifted over to a general diet on the third or fourth postoperative day, and was discharged to active duty on the sixth day.

Complications

Fainting.—The patient sometimes complained of a feeling of faintness during the early stages of the procedure. This was usually due to a combination of factors: (1) he had not eaten for about fifteen hours, (2) he may have had a mild cocaine reaction, (3) he may have been slightly sensitive to the novocaine-adrenalin solution, or (4) the psychic effect of the local head operation may have been considerable.

Treatment was usually not necessary, as spirits of ammonia or simple lowering of the head relieved the feeling in most instances.

Cocaine Reaction.—Mild cocaine intoxications were observed in three cases in this series. The skin was pale and moist, the blood pressure decreased moderately, and respirations were very rapid.

Cheyne-Stokes breathing and cyanosis were observed in one patient, a corpsman who self-atomized his throat a few times extra "for good measure."

I have found that three squirts of an atomizer, with 10 per cent cocaine, will be sufficient for anesthesia and a safe amount to use, barring a real drug idiosyncrasy.

For treatment of such a reaction, intravenous barbiturates are specific, but were not necessary in this series of cases, as they all improved in thirty to sixty minutes on nembutal by mouth. A free airway is essential, however, and a nurse or doctor should be in close attendance.

Hemorrhage.—Bleeding at time of surgery was excessive in approximately 10 per cent. This was controlled by use of single slipknots, ligating as many various bleeding points as necessary.

Postoperative bleeding was infrequent but occurred, invariably on the first or sixth postoperative days. As a result of two Marines' swallowing blood on the first postoperative day without notifying the nurses or corpsmen, we made it a practice to place all patients on their abdomen for the first six hours. Any bleeding would then make itself apparent.

Of the first-day bleeders, twelve patients had to be returned to the operating room for application of catgut by the slipknot technique. (In one instance, previously mentioned, a suture was necessary.) Some thirty to forty others were controlled by morphine sedation and "watchful neglect."

The cause of the sixth-day bleeding, of course, was the loosening of the moist tonsillar fossa scab, with hemorrhage from a small blood vessel. Treatment was necessary in fourteen instances that I know of. It is possible that the regimental doctors handled a few without my knowledge. The clot was removed with tonsillar forceps, and 5 to 8 c.c. of novocaine-adrenalin solution were injected beneath the site of bleeding. I would like to emphasize the usefulness of the novocaine-adrenalin injection in the treatment of a tonsillar bleeder. In the case of a generalized oozing, the pressure exerted by the fluid itself, as well as the vascular constriction caused by the adrenalin, will control the bleeding in a very short time. No attempt was made to ligate the vessel, as the granulation

tissue was difficult to grasp. Occasionally, it was necessary to hold a sponge in the fossa for ten to fifteen minutes to facilitate the clotting mechanism.

Transfusion of whole blood was performed in three instances.

Handling of the Patient.—One of the most frequent complications of a local tonsillectomy is poor co-operation on the part of the patient and, it must be admitted, on the part of the surgeon. Non-coöperative patients were exceedingly rare in this particular survey. The type of individual was most favorable; they all desired to have the procedure performed; the preoperative sedation was adequate; and the local anesthesia was done with great care.

Another important point was the patient's confidence in the operating surgeon. On several occasions when I was instructing Navy interns or flight surgeons, I would anesthetize the patient, remove the right tonsil, and then turn the patient over to the observer for the removal of the left tonsil. Each time the patient responded immediately by not co-operating as well, and a previously absent gag reflex became quite active.

I would like to emphasize the importance of the need for the operating surgeon to remain cool, calm, and collected throughout a local anesthetic procedure. A patient is much easier to handle if an air of quiet confidence permeates the operating room. The very common gag reflex can be easily accentuated by the surgeon losing his self-control, and "barking" at the sedated patient.

Pneumonic Complications.—One patient developed a virus pneumonia on the sixth postoperative day and recovered on symptomatic treatment. There were no cases of lung abscess or atelectasis observed, but these entities should be kept in mind following any throat surgery.

Postoperative Hyperpyrexia. — Any persistent fever was regarded as a local contamination of the tonsillar fossa, the other physical findings being negative. Several patients were treated by penicillin, while sixteen others were given sulfadiazine. It is interesting to note that three of the "sickest" patients postoperatively were boys who had previously suffered from severe peritonsillar abscesses.

Cellulitis or Abscess Formation.—There were no observed abscesses of the surrounding tissues, either parapharyngeal or peritonsillar, following tonsillectomy.

Calcification of Stylohyoid Ligaments.—There was only one instance of a calcification of the stylohyoid ligaments. These were easily palpated in the tonsillar fossa, but were not approached surgically.

Death.—There were no fatalities.

Summary

1. A series of 964 local tonsillectomies are discussed in which the indications for surgery were: (a) recurrent attacks of tonsillitis, (b) history of a peritonsillar abscess, (c) an actively discharging chronic otitis media, or (d) a prophylactic procedure in selected cases of arthritis, rheumatic fever, et cetera.

2. Preoperative sedation is the most important part of a local tonsillectomy, as far as the patient is concerned.

3. Cocaine or pontocaine must be used with caution in the nose or throat. When preceded by nembutal, however, and used sparingly, cocanization of the pharynx is an invaluable adjunct to throat surgery.

4. Novocaine is injected completely around the tonsil. There should be no pain.

5. The application of routine slipknots in the postoperative tonsillar fossa is of definite value.

6. Patients should be placed on their abdomen postoperatively to prevent unsuspected swallowing of blood.

7. The taking of routine clotting and bleeding time is probably a wise procedure, but was of no particular value in this series. The postoperative "oozers" showed no correlation with their clinical clotting times.

8. The most useful single procedure in the stopping of a tonsil bleeder is the injection of a novocaine-adrenalin solution.

HELP THE VETERAN

Doctors holding "Pension Rating" Examination Reports, are requested to send them to Michigan Medical Service as soon as possible, as these reports are needed by the Veterans Administration to adjudicate the veterans' claims.

New Concepts of the Causes of Asthma

By Francis M. Rackemann, M.D.
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If one studies a number of patients with asthma, and tries to compare them one with another, one develops certain concepts concerning the mechanisms of their diseases. Some of the cases appear to fall into groups, and this grouping helps to clarify the over-all picture. At the same time the grouping shows how this patient or that differs from the average run. The trouble is that no classification devised so far is entirely satisfactory, except perhaps in its broad divisions. One is always tempted to improve and redefine the sub-headings. The great difficulty has been that objective evidence is very meager and the classifications made so far have depended primarily—almost entirely—upon the clinical history. This history, however, is of such great practical importance in the clinic that it is quite proper to lay great stress upon it, and to point to several "tricks" in history taking which have proved themselves to be very useful. Let us consider some of these "tricks."

To say that the patient has had asthma for seventeen years means nothing, but to say that the first attack came after whooping cough at age twelve means much. In another person the onset is after the age of forty-five. At onset, one was a young person, the other was middle-aged, and the contrast between them is so definite and clear cut that they represent almost two separate diseases. After all, the word "asthma" means a symptom, and by itself it has little significance. One must know what kind of asthma and what caused it.

The age of onset has become an important, almost a vital, point in the diagnosis. One can say that when asthma begins before the age of thirty, the cause is allergy; but when asthma begins after age forty, the cause is not allergy. Obviously, there are exceptions to these rules, but there are not many exceptions and, on the whole, the rule applies well.

In one case the onset was at age seven, and then after several years the asthma cleared and the child was well for some time until, at the age of eighteen, asthma came again. Why these changes? It is disturbing to find that the average doctor pays little attention to them. Not enough effort is made to find the reason for the improvement at age eleven and the recurrence at age eighteen, and usually the reason is "right there." Where did the family live when the child was age seven, and did they not move when the child was age eleven? Yes, of course! That was the year when they sold the farm and came to town. Then, what about age eighteen? When did the cat come? Was it not about that time? In each case, and particularly in the younger group, it is the history that gives the answer; yet, as said, it is remarkable how "slow" the average doctor is to take full advantage of what he can learn in a short interview.

The first concept, then, is that asthma in young people depends on allergy and that this allergy depends more on dusts than on foods and that the diagnosis of the precise cause depends on the history. Sherlock Holmes would have found out much more about the asthma than Dr. Watson.

Skin tests are interesting. They reveal the degree of sensitiveness, but when skin tests show a positive reaction to some substance which bears no possible relation to the symptoms, and when, again, the patient is clinically sensitive but has no positive tests at all, one must recognize the limitations and the discrepancies of skin tests.

What is "asthmatic bronchitis?" There are patients, particularly young patients, whose asthma occurs only three or four times a year in a short attack, associated always with a new infection (head cold). They wheeze with the cold, and why is this? In some of these patients skin tests are positive, and then one finds later that when the cat is eliminated, or when the pillow is changed, or perhaps when egg is removed from the diet, that then the colds become ordinary colds; there is no wheeze with them. One can show that "asthmatic bronchitis" has the factor of allergy as well as the factor of infection, and treatment can be directed toward either one, or better, toward both. The theory about this is that the patient is slightly sensitive to a food or dust but not enough sensitive to show symptoms at all times. The new cold serves to lower the threshold, to make the

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slight allergy become clinically effective. Experiments to prove this concept in the laboratory are now in progress. Since tuberculous animals are said to be more sensitive than the controls, it looks as though these experiments might be successful.

In the older group, the problems are not so easy or clear cut. Why is it that a man or woman, previously active and healthy in every way, should quite suddenly develop asthma at the age of forty-eight, or perhaps fifty-eight? Is this allergy? Yes, occasionally it is. There are, no doubt, a few cases who develop sensitiveness even at this late age, but I believe they are rare. Sometimes there is clear evidence of an infectious process in the sinus or bronchi, or both, and perhaps someday we will be able to prove the concept of bacterial allergy as the mechanism involved. So far, however, skin tests with bacteria are not satisfactory; they do not often result in the same urticarial reactions that one obtains with cat hair or ragweed.

Elsewhere I have described "depletion" as an important, if not the only, factor in producing asthma in a certain group of patients, and as this concept is used, the group of patients appears large. The "tired businessman" and the "harassed housewife" both belong in it, and in them the depletion concerns the psyche more than it concerns the soma. In others, however, the presence of bad teeth, an infected gall bladder, a chronic prostatitis, or perhaps even a chronic bronchial infection serves to cause the depletion. Particularly interesting are those who have been subjected already to a restricted diet which has resulted in malnutrition, making the depletion worse than ever. Here is evidence that too much treatment is as bad as too little.

Selye of Montreal has helped us immensely by his conception of the "alarm reaction." More recently he calls it the "stress reaction." When a person suffers an injury or a severe infection, he goes into shock, which usually is a temporary matter, but after it the patient is exhausted, nervous and upset; he is "depleted." His pulse is rapid, the blood pressure is low; he is in trouble. Selye calls it the stage of "alarm," and Selye's theory is that in some cases the symptoms and signs may persist indefinitely. The explanation is not yet clear, but the suggestion has been made that the counter shock is concerned in some way with disturbances of adrenal function.

In 1944 there came a French teacher, aged fifty, with a history of heroic effort during the war, doing the work of about three people. She collapsed and soon developed asthma, and in a short time this asthma became of maximum severity. For some months the lady was in actual danger, and treatment had to include transfusions as well as other intravenous medications. Slowly, however, she improved and at the end of a year was able to leave the hospital. I saw her the other day. She had gained 25 pounds in weight; she was outdoors each day; she was eating and sleeping well; she squeezed her adrenalin spray only once or twice in twenty-four hours. Her asthma was under good control and the opinion was that she had recovered from the extraordinary depletion which had pulled her down.

Lesions of the sinuses are very common, so much so that it is proper to regard them as a part of the process and not a cause of it; and, presumably, that is the reason why operations on the sinuses usually do harm and not good. One part of the disease picture is operated upon, the other is left to advance, and in the meantime the normal structure and function of the nose has been destroyed. It is a fact, and it is fortunate indeed that in the last ten years new patients with asthma who give the history of one or two operations on the sinuses are not nearly so common as they were. Polyps in the nose and perhaps in the sinuses themselves are still present but we have learned to leave them alone in most cases. In many patients the local lesion does well and may disappear by itself under "medical" management.

Emphysema can cause asthma. Primary idiopathic emphysema has been described, but the cause of the process, and even its nature, is not at all clear. In older people, especially in men, one recognizes a few patients whose wheezy dyspnea precludes exercise of anything more than a minimal sort. It is important to note that at night these patients sleep well. In contrast to them, "Asthma does not sleep well." The x-ray gives a typical picture, and the barrel-shaped chest develops later. Obviously, it is easy to confuse this condition with my "intrinsic" asthma. No doubt the two conditions are related, but while one is reversible, the other is progressive.

Summary

The diagnosis of the causes of asthma depends always, and chiefly, on the history. The age of

(Continued on Page 350)

Editorial

MICHIGAN FOUNDATION FOR MEDICAL AND HEALTH EDUCATION

THE MICHIGAN STATE Medical Society has been interested for many years in postgraduate medical education, and for the past few years has expanded that program to include health education. A year ago it established a Foundation to carry on its ideas. The Michigan Foundation for Medical and Health Education is a full grown entity with assets of over $116,000. For the past year and a half the urge and the effort have been to get donations of approximately one thousand dollars from our physician members who might be interested and who were able to make such donations. This effort has been quite successful, as the goal of $100,000 has been passed.

The Directors of the Foundation are pleased and now are ready to extend their efforts. They hope to make this foundation one of appeal and of vision, with at least $5,000,000 as the ultimate goal. All the physicians of the state are interested in the purposes of this organization, all will benefit indirectly from its functioning and we are sure will want to be identified with its aims. When Michigan physicians become enthusiastic in any undertaking they have a way of driving through to the ultimate goal in a way to assure success.

A brochure describing the Foundation and its ambition has been published and is now ready for distribution to those who will be possible benefactors. We believe in the medical profession of Michigan, and know that most of them will want to be included in the list of donors. When we want something done we proceed to do it and now we want this Foundation to succeed. Some of our members are not so situated that they can make big donations to any cause no matter how worthy, but there are very few who cannot make a donation of some amount.

The call for the first year was for one hundred to give one thousand dollars. Now, if an equal number would give five hundred, one hundred, twenty-five and ten dollar gifts that would soon mount into a respectable endowment, and we would be able to ask the general public to support a plan which we had demonstrated as already secure.

Let Us All Do as Much as We Can

A Committee on Contributions was established by the Foundation at its meeting, February 2, to contact every member and offer him a chance to subscribe to this worthy foundation. If each Doctor of Medicine in the state would send his contribution voluntarily to the President of the Foundation, E. I. Carr, M.D., 2020 Olds Tower, Lansing 8, Michigan, and not wait to be contacted, he would render a service, and conserve the time and efforts of some of his fellow practitioners who would otherwise have to call upon him.

This is a worthy cause, and let's all help. Let's make that help available now.

RURAL MEDICAL SERVICE

TO SUPPLY RURAL AREAS with sufficient and satisfactory health service is a problem suitable to Solomon in all his glory. We just heard of a discussion among several doctors who had moved to larger towns after or during the war, and had left their various former rural areas without doctors, or to the mercy of cultists. These doctors served for eight to ten years in their rural areas, and are now being besieged by their former patients to find some way to get doctors to locate in those communities. Some of these doctors served in the armed forces. These young doctors are asking—What is the Medical Society doing to relieve the needs of these rural people? Why do they not do something? Why not get some young doctors to settle in those small places? It is time someone did something. And so on, **ad infinitum.**

What has the profession done? Why do they not do something? The Council of the Michigan State Medical Society has had an active Committee on Rural Health for a considerable time, and the American Medical Association has been working along this line. On February 7 and 8, 1947, the second annual Conference on Rural Medical Service was held in Chicago under the auspices of the American Medical Association with speakers from all over the United States, representing medicine, grange, farm activities and many farm organizations. The editor attended the first of these meetings last year and was impressed

with the amount of study given the subject, the ramifications of the problem, and the almost impossible obstacles to be overcome.

Most young doctors, even those who grew up on the farm, will not locate for practice in a town removed from immediate contact with a suitable hospital. They feel that they must have laboratory and other facilities at hand if they are to do their best work, and the farm groups claim they will not consider the needs of remote communities when it means they will have to make shift for the easy aids they have been taught to use. Subsidies have been tried, clinic buildings have been offered, and no takers. That is why some of these groups have favored compulsory medical service, thinking, mistakenly, that this would bring good doctors to their communities. We realize this will not bring the desired result, for with freedom of work and life no one can tell the young doctors, or the older ones, either, where they must practice.

This philosophy of living in America has defeated all efforts so far to induce young doctors to go to small communities for a few years. The Deans of our medical schools are besieged with requests to send young graduates to rural areas. The editor has had two appeals from Mackinac Island this winter. The island is isolated during the winter, and has only about five hundred inhabitants at that time, but those five hundred need a doctor. During the resort season the doctor's time is well occupied but during the dull months the resident people also need help. The Island will furnish an office and a considerable monthly stipend in addition to what the doctor makes from his practice. This request was published in THE JOURNAL some months ago.

Dean H. A. Kemp of Wayne University offered a suggestion at a conference on this subject during the Michigan State Medical Society Public Relations and County Secretaries' Conference at Detroit, February 2, 1947. Someone had suggested to him that rural doctors invite young senior students to spend the summer as guests in their homes and offices, thus demonstrating the trials and services of rural practice. The idea was that the compensations and satisfactions are such that many young men would be induced to try such practice for a few years after internship.

Better men than we have studied this problem for years, and are still trying to find a solution. This impasse must be solved for the good of our great and worthwhile rural population. If any of our members have suggestions, we would be glad to receive and air them.

Is it possible that after a few years many doctors will gradually go out into the smaller but up-and-coming communities much as they did after the last war? A temporary turnover following such an event as a war is taking place which will adjust itself in a satisfactory manner in time.

And, by the way, a serious complaint comes from our rural areas that doctors when consulted, rural or city, do not give their cases sufficient time and study. Rural patients come in while the doctor is rushed, and feel that they are pushed through too rapidly. This is being reported as a hint. Here is a place for good public relations. A very few minutes spent listening to an oft-told story may pay big dividends.

CANCER DETECTION CENTERS

CANCER HAS BECOME one of the most frequent causes of death, now that life expectancy has advanced well into the cancer age. There may be proportionally more cancers, but we like to believe the apparent increase is due to our habit of living longer, by some thirty years, and thus becoming more susceptible.

The most certain way to prevent so many cancer deaths is to find the cases early. After they are once found, the problem is comparatively simple. Cancer detection centers were suggested many years ago, and some efforts were made to carry them out. In late years some actual progress has been made. There are several such centers now in operation in Michigan. Misgivings on the part of doctors as well as the laity have been manifest, but assurance is growing that these centers can and do make valuable assistance and techniques available, and give the benefit of expert consultation to those patients who might not be able to secure such help.

The doctors have been assured that their patients who are referred to the centers will invariably be returned to them, with expert advice, and the doctors are becoming more and more cooperative. These consulting centers have been sponsored by the Cancer Committee of the State Medical Society, and the Society itself has given its endorsement of this aid in the early finding

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Proceedings of the Detroit Physiological Society

Session of December 12, 1946

Factors Influencing Nausea and Vomiting Following Intravenous Amino Acid Administration

Charley J. Smyth, M.D., Stanley Levey, Ph.D. and Andrew G. Lasichak, M.D., Eloise, Michigan.

In previously published work we have demonstrated that supplementary oral protein feedings cause neither a reduction in the appetite nor nausea or vomiting; whereas, casein hydrolysates both acid and enzymic when given intravenously produce these undesirable symptoms, particularly when administered at rapid rates. This study was conducted in order to find a mixture of amino acids which could be given at rapid rates to permit the administration of large amounts without ill effects. In these studies five mixtures were used: two were acid hydrolysates of casein, one an enzymic hydrolysate of casein, and two were mixtures of pure amino acids.

The influence of rates varying from 5 c.c. to 100 c.c. per minute were studied in ninety-one individuals. The occurence of nausea and vomiting was related to the mixture given rather than the rate of administration. The amino acid mixtures could be administered at rates three times that of the casein digests without producing ill effects.

The possibility that hyperaminoacidemia was responsible for the ill effects was investigated in ninety-seven subjects. In those subjects who received the acid hydrolysates there was a direct correlation between the incidence of nausea and vomiting and the height of the blood amino acid nitrogen levels; with levels of 10 mg. per cent or greater, nausea or vomiting usually occurred. With amino acid mixtures nausea and vomiting was rare even though blood amino nitrogen levels were high.

The reduced tolerance of casein hydrolysates compared with amino acid mixtures is attributed to the high content of glutamic acid in the protein digests. That this is the probable explanation is supported in part by the high incidence (79 per cent) of nausea and vomiting in seventeen subjects who received glutamic acid added to mixtures of synthetic amino acids.

The Use of Buffered Thrombin in Control of Upper Gastrointestinal Bleeding

Byrne M. Daly, Departments of Physiology and Surgery, Wayne University College of Medicine.

The clinical application of thrombin as supportive therapy in cases of hemorrhage from the upper gastrointestinal tract has proved to be effective. In certain instances bleeding is of such a character that thrombin cannot be expected to be effective and in those instances, surgical intervention is indicated.

When thrombin is used for this purpose it is necessary to take proper account of the fact that acids destroy it at pH 4. The stomach contents are therefore considerably too acid for mixing with thrombin. This difficulty can be overcome. It has been shown that M/7 phosphate buffer of pH 7.6 can be given by mouth in such a way as to neutralize the acidity of the stomach sufficiently to permit active thrombin to exist in the stomach for a period of ten minutes or more.

Thirty-five different individuals were given 30 c.c. of the buffer by mouth. Five minutes later 30 c.c. of buffer containing 10,000 units of thrombin were also given. Five minutes later part of the stomach contents were aspirated and active thrombin was present in thirty-one of the samples. In the other cases, irregularities were encountered.

The cases treated were admitted to Receiving Hospital with hematemesis and a history of peptic ulcer. They were first given 30 c.c. of the buffer by mouth and after five minutes the buffered thrombin (10,000 units in 30 c.c.). In most cases there was no evidence of hemorrhage following this therapy.

It is felt that thrombin is effective in arresting hemorrhage of the upper gastrointestinal tract and can, therefore, be used as supportive therapy.

The Hypophysio-Portal System

J. D. Green, Department of Anatomy, Wayne University College of Medicine.

Since the pars distalis of the adenohypophysis is influenced by the nervous system but contains

very few nerve fibers, Dr. G. W. Harris and myself became interested in the possibility of a neurovascular mechanism, suggested previously by Harris and several others.

The hypophysio-portal system appeared to require further study since it had previously been described in only a few forms and some dispute still existed about its extent and direction of flow. Examination of the dog hypophysis showed a system of capillary loops (described by Wislocki) which projected into the median eminence. These loops were subsequently found in all the animals investigated (rat, guinea pig, rabbit, dog, macaque, and man), and it appeared that the majority of the blood reaching the pars distalis passed first through them and then into large channels, the hypophysio-portal vessels. Wislocki's opinion that the portal vessels conveyed blood to the adenohypophysis was confirmed and an association between the looped capillaries and nerve fibres from the hypothalamico-hypophysial tract was noted.

It is suggested that, under neural influences, an excitatory substance may be produced within the median eminence which is conveyed by the portal vessels to the pars distalis. Alternatively the pars distalis may be controlled by a vasomotor mechanism. Such hypotheses accord well with the observations of many authors on the importance of the median eminence in the regulation of gonadotrophic hormones and may also account for the peculiar arangement of the pars tuberalis and for discordant reports on hypophysial stalk section.

Session of January 16, 1947

Development of Asymmetry in the Morphogenesis of the Amphibian Digestive Tract

Norman E. Kemp, Department of Biology, Wayne University College of Medicine.

Entoderm of the early neurula stage of *Hyla regilla,* the West Coast tree frog, lacks potency for histological regulation, but possesses marked powers of morphological regulation. Four types of experiments supported these conclusions.

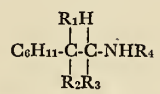
In the first series of experiments, lateral halves of embryos were fused in reversed antero-posterior direction; in the second series, parts of the midgut were extirpated; in a third series, embryos developed with duplicated segments of midgut; and in the last series, sections of midgut were rotated 180 degrees.

Development of form of the coelomic entodermal derivatives is believed to be dependent in large part upon the molding influence of mesodormal structures associated with the gut. In particular, transverse septum and dorsal mesentery appear to play important roles in the development of asymmetry in the digestive organs.

The Pharmacologic Activity of Some β-Cyclohexylalkylamines

Bernard L. Zenitz, Frederick Stearns & Company, Division of Sterling Drug, Inc.

Many derivatives of β-phenylethylamine have been prepared and found to possess sympathomimetic activity. However, only a comparatively few derivatives of β-cyclohexylethylamine have been investigated for such activity, although many have been studied in the antispasmodic field. Therefore, in order to determine the effect of the replacement of the phenyl nucleus by a cyclohexyl group on sympathomimetic activity, a series consisting of fifteen alkyl derivatives of β-cyclohexylethylamine was prepared. The members of this series have the general structure:



where R_1, R_2 and R_3 = H or CH_3; and R_4 = H, CH_3 or C_2H_5.

A comparative pharmacologic study of the pressor activity, toxicity and central nervous system stimulation of these compounds indicates that:

1. The most pressor members of the series are N-methyl-β-cyclohexylethylamine and levo-N-methyl-β-cyclohexylisopropylamine which are approximately 1/160 to 1/185 as active as epinephrine.

2. N-Methylation of β-cyclohexylethylamine increases pressor potency, as well as toxicity; while N-ethylation only slightly decreases pressor activity.

3. The introduction into β-cyclohexylethylamine of either an α-methyl ($R_3 = CH_3$) or both an α-methyl and an N-methyl group (R_3 and $R_4 = CH_3$) also increases pressor potency, but at the same time toxicity is increased.

4. Substitution of β-methyl groups into either β-cyclohexylethylamine or β-cyclohexylisopropylamine decreases pressor activity. As the number of methyl groups substituted into the ethylamine

side chain increases above one, pressor activity is decreased.

5. The duration of pressor activity of the cyclohexyl compounds is comparable to their corresponding phenyl analogs; those having an ethylamine side chain have a short duration, those with an isopropylamine side chain (α-methyl group) have a prolonged duration.

6. The cyclohexyl compounds produce only a small amount of central stimulation in rats. Doses of 20 or 30 mg./kg. subcutaneously produce much less stimulation than a dose of 1 mg./kg. of d-desoxyephedrine.

In view of the volatility of the bases and their freedom from excitatory central effects, the more active compounds of the series may find application as volatile nasal decongestants or, in the form of their salts, as general vasoconstrictors in cases where central excitation is an undesirable side-effect.

Experimental Studies of Malaria in Cold-Blooded Animals

Paul E. Thompson, Research Parasitologist, Parke, Davis & Co.

An examination of approximately 2,000 lizards procured from several localities in North and Central America revealed three new species of *Plasmodium* and sources of malaria-free lizards suitable for experimental purposes.

Plasmodium mexicanum N. sp. produces exoerythrocytic stages in its vertebrate hosts. This parasite invades tissue cells as well as all types of blood cells including erythrocytes, granulocytes, lymphocytes and thrombocytes. The demonstration of exoerythrocytic stages in saurian malaria is significant in view of their known existence in avian malaria and of their probable occurrence in human malaria.

Blood-induced infections produce an acquired immunity. The immune response is accompanied by a statistically significant reduction in the mean number of merozoites per schizont and by alterations in the morphology and staining reactions of the parasites.

Studies of the effects of temperature on the rate of parasite reproduction *in vivo* revealed that the rate of reproduction is accelerated by an elevation of the hosts' temperature. Between 20° and 30° C. *Plasmodium floridense* N. sp. was found to have a Q_{10} of 5.43.

Chemotherapeutic studies showed that quinine and atabrine are active against the saurian plasmodia. The antimalarial activity of these drugs against the parasites of lizards was found to resemble their activity against the parasites of man and other warm-blooded hosts. Both drugs reduced the mean number of merozoites per schizont and caused visible damage to the parasites.

HYPERTENSIVE HEART DISEASE

(Continued from Page 317)

5. Goldblatt, H.; Gross, J., and Hanzel, R. F.: Studies in experimental hypertension. II. Effect of resection of splanchnic nerves on experimental renal hypertension. J. Exper. Med., 65:233, (Feb. 1) 1937.
6. Goldblatt, H.; Lynch, J.; Hanzel, R. F., and Summerville, W. W.: Studies on experimental hypertension: The production of persistent elevation of systolic blood pressure by means of renal ischemia. J. Exper. Med., 59:347, (March) 1934.
7. Goldring, W., and Chasis, H.: Hypertension and Hypertensive Disease. New York: The Commonwealth Fund, 1944.
8. Gull, W., and Sutton, H.: On the pathology of the morbid state commonly called chronic Bright's disease with contracted kidney (arterio-capillary fibrosis). Med. Cbir. Trans., 55:273, 1872.
9. Herxheimer, G., and Scbulz, K.: Statisches zum Kapital Bluthochdruck, Herzhypertrophie, Nierenarteriolosklerose, Gehirnblutung nach anatomische, Befunden. Klin. Wchnschr., 10:433, 1931.
10. Janeway, T. C.: A clinical study of hypertensive cardiovascular disease. Arch. Int. Med., 12:755, 1913.
11. Johnson, G.: I. On certain points in the anatomy and pathology of Bright's disease of the kidney. II. On the influence of the minute blood vessels upon the circulation. Med. Cbir. Trans., 51:57, 1868.
12. Mahomed, F. A.: The etiology of Bright's disease and the prealbuminuric stage. Brit. M. J., 1:585, (May 2) 1874.
13. May, O.: Mortality in relation to hyperpiesia. Brit. M. J., 2:1166, 1925.
14. Murphy, F. D.; Grill, G.; Pessin, B., and Moxon, G. F.: Essential (primary) hypertension: A clinical and morphological study of 375 cases. Arch. Int. Med., 6:31 (July) 1932.
15. New York Academy of Sciences: Special conference on experimental hypertension. In special publication of the Academy, 3:1-180, 1946.
16. Page, I. H., and Helmer, O. M.: A crystalline pressor substance (angiotonin) resulting from reaction between renin and renin activator. J. Exper. Med., 81:29, (Jan.) 1940.
17. Traube, L.: Ueber den Zusammenhang von Herz und Nierenkrankheiten. Berlin, 1856: Gesammelte Beitrage, 2:290, 1870.
18. Volhard, F.: Nierenerkrankungen und Hocbdruck, 1942.
19. Volhard, F., and Fabr, K. T.: Die Brightische Nierenkrankheit. Klink Pathologic und Atlas. Berlin: Julius Springer, 1914. 1914.

ENDOCRINE GLANDS

(Continued from Page 321)

10. Haines, S. F., and Keating, F. R., Jr.: Clinical use of thiouracil. M. Clin. North America, 30:845-854, (July) 1946.
11. Hertz, Saul, and Roberts, Arthur: Radioactive iodine in the study of tbyroid pbysiology. J.A.M.A., 131:81-86, (May 11) 1946.
12. Keating, F. R., Jr., and Cook, E. N.: Hyperparatbyroidism without evidence of bone disease: report of case. Proc. Staff Meet., Mayo Clin., 19:159-163, (Mar. 22) 1944.
13. MacKenzie, C. G., and MacKenzie, Julia B.: Effect of sulfonamides and tbioureas on the thyroid gland and basal metabolism. Endocrinology, 32:185-209, (Feb.) 1943.
14. Mandl, Felix: Therapeutiscber Versuch bei einem Falle von Ostitis fibrosa generalisata mittels Exstirpation eines Epitbelkörperchentumors. Zentralbl. f. Cbir., 53:260-264, (Jan. 30) 1926.
15. Van Winkle, Walton, Jr.; Hardy, S. M.; Hazel, G. R.; Hines, D. C.; Newcomer, H. S.; Sharp, E. A., and Sisk, W. N.: The clinical toxicity of thiouracil; a survey of 5,745 cases. J.A.M.A., 130:343-347, (Feb. 9) 1946.
16. Williams, R. H.: Thiouracil treatment of thyrotoxicosis. I. The results of prolonged treatment. J. Clin. Endocrinol., 6:1-22, (Jan.) 1946.
17. Williams, R. H.; Clute, H. M.; Anglem, T. J., and Kenney, F. R.: Thiouracil treatment of thyrotoxicosis. II. Toxic reactions. J. Clin. Endocrinol., 6:23-51, (Jan.) 1946.

Michigan State Medical Society

SECRETARY'S ANNUAL REPORT—1946

I herewith submit the report of the Secretary for the year 1946.

Membership

The Michigan State Medical Society membership for 1946 showed a total of 4,810 members, including 46 Emeritus members, 3 Life members, 12 Retired members, and 1,416 Military members. The total paid memberships were 3,322 with net dues of $34,820.69. In addition, credit of $8,137.50 was taken for 775 military members for whom dues were set aside until their return to civilian status. The total amount credited to society dues for 1946 was $42,958.19. The total number of members with unpaid dues for 1946 was 122.

The membership tabulation for the years 1945 and 1946 showing the net gains, losses, unpaid dues, and deaths is as follows:

Membership Record—1946

County	Paid 1945	Military 1945	Paid 1946	Military 1946	Gain	Loss	Unpaid	Deaths
Allegan	17	3	17	2	0	0	1	0
Alpena-Alcona-Presque Isle	11	6	12	7	1	0	0	0
Barry	10	3	8	4	0	2	0	0
Bay-Arenac-Iosco	51	26	48	28	0	3	1	2
Berrien	47	10	48	12	1	0	4	0
Branch	17	8	18	8	1	0	0	1
Calhoun	67	38	65	38	0	2	3	3
Cass	10	2	9	2	0	1	1	0
Chippewa-Mackinac	14	6	12	5	0	2	2	0
Clinton	10	4	9	2	0	1	0	0
Delta-Schoolcraft	18	5	17	6	0	1	0	1
Dickinson-Iron	16	4	14	3	0	2	2	0
Eaton	14	7	13	7	0	1	2	0
Genesee	136	50	135	60	0	1	4	4
Gogebic	16	2	18	2	2	0	0	0
Grand Traverse-Leelanau-Benzie	34	12	34	15	0	0	1	0
Gratiot-Isabella-Clare	25	12	24	12	0	1	1	0
Hillsdale	19	6	13	5	0	6	5	1
Houghton-Baraga-Keweenaw	28	7	27	9	0	1	1	2
Huron	11	0	12	0	1	0	0	0
Ingham	115	39	121	54	6	0	1	0
Ionia-Montcalm	29	10	26	11	0	3	1	0
Jackson	70	28	69	40	0	1	0	4
Kalamazoo	75	41	78	44	3	0	2	1
Kent	176	84	178	102	2	0	5	1
Lapeer	10	3	10	4	0	0	0	0
Lenawee	25	14	23	15	0	2	3	0
Livingston	13	5	14	5	1	0	1	0
Luce	5	3	6	5	1	0	1	0
Macomb	26	11	30	14	4	0	1	0
Manistee	9	2	8	4	0	1	0	0
Marquette-Alger	28	10	26	9	0	2	1	0
Mason	7	4	7	4	0	0	0	0
Mecosta-Osceola-Lake	9	3	11	3	2	0	0	1
Med. Soc. of North Central Counties	12	3	13	1	1	0	1	0
Menominee	11	0	10	5	0	1	0	1
Midland	15	2	12	5	0	3	2	1
Monroe	29	11	28	12	0	1	1	1
Muskegon	62	17	56	22	0	6	1	0
Newaygo	7	1	7	1	0	0	0	0
Northern Michigan	24	6	26	5	2	0	1	1
Oakland	112	42	120	47	8	0	3	0
Oceana	8	3	7	3	0	1	1	0
Ontonagon	3	0	3	2	0	0	0	0
Ottawa	22	9	24	9	2	0	0	0
Saginaw	62	33	66	41	4	0	2	2
Sanilac	10	3	10	3	0	0	0	0
Shiawassee	13	8	17	10	4	0	0	0
St. Clair	44	7	37	11	0	7	1	2
St. Joseph	16	10	14	12	0	2	1	2
Tuscola	13	5	16	5	3	0	0	0
Van Buren	20	10	14	10	0	6	2	0
Washtenaw	144	64	138	38	0	6	18	3
Wayne	1583	539	1529	625	0	54	44	15
Wexford	17	6	15	8	0	2	1	0
Total	3395	1245	3322	1416	49	122	122	49

Deaths During 1946

We regretfully record the deaths of the following forty-nine members during 1946. In addition to these listed, deaths of at least thirty-three former members were reported to the Executive Office.

Bay-Arenac-Iosco—M. R. Slattery, M.D., Bay City; Kenneth Stuart, M.D., Bay City.

Branch—S. E. Far, M.D., Quincy.

Calhoun—Jesse J. Holes, M.D., Battle Creek; Clara V. Radabaugh, M.D., Battle Creek; Paul Roth, M.D., Battle Creek.

Delta-Schoolcraft—A. S. Kitchen, M.D., Escanaba.

Genesee—R. W. MacGregor, M.D., Flint; Elta Mason, M.D., Flint; John W. Moore, M.D., Flint; G. R. Wright, M.D., Montrose.

Hillsdale—Fred B. Fisk, M.D., Jonesville.

Houghton-Baraga-Keweenaw—James C. Abrams, M.D., Calumet; Frank F. Marshall, M.D., L'Anse.

Jackson—Edward D. Crowley, M.D., Jackson; Isaac N. La Victoire, M.D., Jackson; C. W. Schepeler, M.D., Brooklyn; John W. Speck, M.D., Jackson.

Kalamazoo—W. W. Lang, M.D., Kalamazoo.

Kent—Frederick Cook Warnshuis, M.D., Windsor, Ontario;

Mecosta-Osceola—V. J. McGrath, M.D., Reed City.

Menominee—Stephen C. Mason, M.D., Menominee.

Midland—Gust Sjolander, M.D., Midland.

Monroe—J. A. Humphrey, M.D., Monroe.

Northern Michigan—Lyle D. McMillan, M.D., Mackinaw City.

Saginaw—William J. O'Reilly, M.D., Saginaw; Dale Thomas, M.D., Saginaw.

St. Clair—W. P. Derck, M.D., Port Huron; W. W. Ryerson, M.D., Port Huron.

St. Joseph—David M. Kane, M.D., Sturgis; Ray E. Dean, M.D., Three Rivers.

Washtenaw—James D. Bruce, M.D., Ann Arbor; David N. Robb, M.D., Ypsilanti; J. B. Wallace, M.D., Saline.

Wayne—Edward J. Agnelly, M.D., Detroit; Willard E. Fischer, M.D., Wayne; Arthur L. Gignac, M.D., Detroit; Landy E. Harris, M.D., Detroit; Robert C. Jamieson, M.D., Detroit; L. R. Kaminski, M.D., Detroit; Wm. C. Lawrence, M.D., Detroit; Roman H. Maior, M.D., Hamtramck; G. L. McClellan, M.D., Detroit; Frank T. McCormick, M.D., Detroit; James H. Sanderson, M.D., Detroit; Rollin H. Stevens, M.D., Detroit; Norman G. Tufford, M.D., Detroit; W. K. Ward, M.D., Detroit; Frederic S. Wilson, M.D., Detroit.

Financial Status

Ernst and Ernst, Certified Public Accountants, have submitted their report on the annual audit of the books of the Michigan State Medical Society. The report has been submitted to the officers of the Society and members of the Finance Committee, and is subject to the perusal of all members of the State Society.

A brief summary of the auditors report is submitted for information of the members:

Total assets of the Society as of December 31, 1946 ....$ 158,762.93
Showing an increase for the year of .....$ 35,463.75
Included in the assets are securities valued at cost* .....$ 82,860.15
Demand deposits, cash on hand and savings deposits totaled at the end of the year ....$ 64,474.81
Accounts receivable .....$ 11,427.97
Totaling this, we have the assets of the Society, as stated above.
*Redemption value of these securities, as of December 31, 1946.....$ 81,817.40
Income from Membership Fees.....$ 39,760.19
Of this amount $6,102.00 was allocated for subscriptions to THE JOURNAL.

Interest on securities and time deposits was	$ 1,821.29
Total cash income	$ 54,390.49
From this we may deduct expenses of administrative and general nature, together with Societies' activitives, annual session expense and committee expense	$ 43,466.50
Making a total net income of	$ 10,923.99
In the Public Relations Account there was at the beginning of the year a balance of	$ 12,150.00
Assessments collected during the year	$ 82,344.00
Making a total in the Public Education Account	$ 94.494.00
Total expenditures of the Public Educational Program amounted to	$ 50,879.98
Balance of unexpended funds	$ 43,614.02
of whicb $30,000—earmarked for this special account —that is Public Relations Account—has been invested in Government Bonds, purchased at a face value of $30,000.	
THE JOURNAL was published at an actual cost of	$ 51,344.00
Whereas, the revenue derived from subscriptions, advertising sales and reprints totaled	$ 60,748.26
Showing a net income of	$ 9,404.26
Tbus showing slight increase in earning capacity over the year 1945, when the net income was listed as	$ 7,695.21
Committee expenses totaled	$ 5,979.94
showing slight increase over 1945.	
During the year there have been tranferred to the Michigan Foundation for Medical and Health Education funds previously held in the Michigan Education Program funds totaling	$ 23.400.86

1946 Annual Meeting

The 1946 Annual Session, held in Detroit, showed a total registration of 2,866, which was an all-time high in attendance at an Annual Meeting of The Michigan State Medical Society.

The General Assembly type of program with daily discussion conferences was continued as in previous recent years.

The limited space available in Detroit precluded the possibility of having a Scientific Exhibit.

The policy of bringing to the Scientific Assembly out-of-state essayists of national and international reputation was continued, and no expense was spared in making the meeting as interesting and attractive as possible. Despite the great expense incurred in maintaining the high standard of the Michigan Meeting, and the smaller number of Technical Exhibitors who could be accommodated in Detroit, a substantial net profit accrued to the Society. To the eighty Technical Exhibitors the registrants showed their usual appreciation and gave them very generous attention.

County Secretary Conferences

Two conferences of County Society Secretaries were held during 1946. Both were held in Detroit—one in January and one in September on the occasion of the Annual Meeting. A Public Relations Conference was held in Lansing, February 21, which some 80 county society public relations officers and key men and representatives of the Womens' Auxiliary attended. The speakers on this new type of program in medical organizational work were:

E. B. Harper ..... East Lansing
J. W. Holloway, Jr. ..... Chicago
R. L. Sensenich, M.D. ..... South Bend
A. S. Brunk, M.D. ..... Detroit
E. F. Stegen ..... Chicago
T. A. Hendricks ..... Chicago

These conferences have served to publicize to the component societies many of the major activities of the State Society and information necessary for the development of modern public relations techniques.

Committees

Limitation of time and space makes it impossible to detail in this report the activities of all the committees contributing to the many programs of the State Society. During 1946 there was a total of 57 committees engaged in some State Society project. The work of these groups was greatly enhanced by enlarged personnel made possible by the return of many military members to active practice.

Many of the committees of the Society have developed long-range programs, and the effects of such planning is becoming more and more apparent as these projects continue to expand and mature.

During the year there was a total of eighty committee meetings held.

Society Activities

Councilor District Meetings.—During the year Councilor District Meetings were held in 14 districts. These meetings were attended by various members of the administrative personnel who made up-to-the-minute presentations of State Society activities. These meetings were designed to allow a discussion of various questions presented by the members.

Michigan Postgraduate Clinical Conference.—This scientific conference sponsored by the Michigan State Medical Society, in co-operation with the University of Michigan Medical School and Department of Postgraduate Medicine, Wayne University School of Medicine, the Michigan Foundation for Medical and Health Education and the Wayne County Medical Society, was conceived and planned in 1946. The first Annual Conference will be held in Detroit, March 12, 13, and 14, 1947. This conference, all of whose essayists are members of the Michigan State Medical Society, will provide a high-grade scientific program, will encourage the preparation of papers by Michigan men, and will publicize Michigan as a medical center.

Rheumatic Fever Program.—This unique medical-society-operated diagnostic and consultation program is progressing. Centers in Ann Arbor, Bay City, Detroit (2), Flint, Grand Rapids, Jackson, Kalamazoo, Lansing, Marquette and Traverse City are in operation or in the process of being organized. The program has been made possible by the generous contribution of participating doctors of medicine and that of $15,000.00 made by the Michigan Society for Crippled Children and Disabled Adults to finance the program. An excellent working spirit of co-operation has existed between the Michigan Society for Crippled Children and Disabled Adults, The Michigan Crippled Childrens' Commission and the Michigan State Medical Society in the initial operation of the rheumatic fever program in Michigan.

Veterans' Committee.—Pursuant to instructions of the 1946 House of Delegates a committee on State Veterans Affairs has been appointed as follows:

L. E. Sevey, M.D. ..... Grand Rapids, Chairman
Grover C. Penberthy, M.D., Detroit, Vice Chairman
W. W. Babcock, M.D. ..... Detroit
C. W. Brainard, M.D. ..... Battle Crek
O. A. Brines, M.D. ..... Detroit
Wm. Bromme, M.D. ..... Detroit
W. C. C. Cole, M.D. ..... Detroit
W. E. Ellet, M.D. ..... Benton Harbor
H. B. Fenech, M.D. ..... Detroit
James Fyvie, M.D. ..... Manistique
J. V. Fopeano, M.D. ..... Kalamazoo
R. F. Hague, M.D. ..... Flint
S. W. Hartwell, M.D. ..... Muskegon
J. E. Ludwick, M.D. ..... Jackson
K. S. McIntyre, M.D. ..... Hastings
H. C. Mitchell, M.D. ..... Grand Rapids
W. E. Nesbitt, M.D. ..... Alpena
C. I. Owen, M.D. ..... Detroit
F. H. Power, M.D. ..... Traverse City
C. W. Reutter, M.D. ..... Bay City
Paul Schrier, M.D. ..... Kalamazoo
J. M. Sheldon, M.D. ..... Ann Arbor
R. W. Teed, M.D. ..... Ann Arbor
J. M. Wellman, M.D. ..... Lansing
Stuart Yntema, M.D. ..... Saginaw

Contacts with Governmental Agencies

Michigan Crippled Childrens' Commission.—Contacts with the M.C.C.C. has resulted in its adoption of the Uniform Fee Schedule for Governmental Agencies within its statutory limits. These latter limits or ceilings call for an amendment to the commissions' Acts whereby the ceiling of $75.00 for surgical procedures can be raised consistent with general commodity costs. Adoption of

the Uniform Fee Schedule for Governmental Agencies, in whole or part, has been announced by the Veterans Administration, Office of Veterans Affairs, State Board of Vocational Rehabilitation, The State Social Welfare Commission and various county boards of social welfare.

State Association of County Supervisors and Social Welfare Agencies.—During the year an appearance was made before the Annual Meeting of the Association of County Supervisors and Social Welfare Agencies with a view to explaining the Uniform Fee Schedule for Governmental Agencies and its philosophy.

State Board of Registration in Medicine.—After many meetings and much effort on the part of a special committee, the State Board of Registration in Medicine changed its ruling so that interns may complete their second year of training in an approved hospital without a license to practice, thus eliminating a great deal of hardship and enabling interns and residents to continue their respective services in Michigan.

Taft Health Bill.—By official invitation a special committee of the Michigan State Medical Society has been actively working on suggested revisions of the Taft Health Bill.

Federal Hospital Survey and Construction Program.—Various regional meetings have been held throughout the State—sponsored by the Michigan Hospital Association—to discuss the Federal Hospital Survey and Construction Program and proposed model hospital licensing bill in Michigan. These conferences were attended by various Officers, Councilors, and members of the Michigan State Medical Society.

Courses in Medical Economics

During 1946 there were introduced in the Medical School of the University of Michigan and Wayne University Medical School courses in Medical Economics given by practicing physicians.

American Academy of Pediatrics Survey of Child Health Care.—The Michigan State Medical Society stands almost alone among the various state medical societies in its practical co-operation with its state branch of the American Academy of Pediatrics in the latter's survey of child health care. The Michigan survey which was conducted through a co-operative effort of the Academy of Pediatrics, the Michigan State Medical Society, and the Michigan Society for Crippled Children and Disabled Adults, has been eminently successful.

Michigan Department of Health.—Many contacts were made with the state department of health in 1946. These contacts were arranged in an effort to maintain a co-operative relationship with the health department. Various projects have been jointly sponsored by the two organizations.

Awards

The establishment of a committee on Awards was accomplished in 1946. Through the program set up by this committee it is possible, by recommendation of County Societies or the State Society, that certificates of appreciation can be presented to lay individuals, groups or organizations who have made outstanding contributions to medical progress and publicity.

Secretary Letters

As part of the Society's general educational program for individual members and component county societies there were issued during the year 10 Secretary's Letters, 6 to county secretaries and key men and 4 to all members of the Michigan State Medical Society.

With a return to active practice of most of the military members of the State Society the tempo of society activity should be considerably accelerated and reflected in the future achievements of the organization in scientific advancement and in solution of its ever apparent socio-economic problems.

I respectfully submit the following recommendations for your consideration—

1. A continuation of a progressive public relations program in 1947, utilizing to the fullest extent the co-operation of the individual physicians in their home communities contacting friends and patients in a general educational campaign.

2. Continue pressing by county medical societies for adoption by all governmental users of medical service of the Uniform Fee Schedule for Governmental Agencies.

3. Urge individual members to contact legislators with a view to having the Afflicted and Crippled Child Acts amended to more adequately and justly serve the clients thereof and the purveyors of the technical services.

4. A definite attempt be made to provide more office space so desperately needed for the Executive Office.

5. Continue the practice of holding councilor district meetings in 1947.

Your secretary desires to express to this Council his sincere appreciation of its fine co-operation and encouragement during 1946. Much commendation is due the committees for their untiring efforts in originating and executing their many splendid projects and programs.

To Mr. Burns, Executive Secretary, Mr. Brenneman, Public Relations Council, and the Executive Office personnel, I wish to express personal appreciation of their hearty co-operation and cheerful assistance at all times. It is with extreme gratification that I record the return from the armed forces of Major Lynn Leet to his former position in the Executive Office.

To Mr. Burns, especially, for his splendid co-operation, wise counsel and inspiration, and to all those who have aided so generously in the discharge of the duties of this office, your secretary is most grateful.

Respectfully submitted,
L. Fernald Foster, M.D.,
Secretary.

January 31, 1947

EDITOR'S ANNUAL REPORT—1946

Volume 45 of The Journal of the Michigan State Medical Society is now complete. The Journal has been published regularly during the year, but has continued to be a little later as the year progressed. We thought there would be an increasing promptness until we could be on time, but in spite of all effort there has been delay. The fact that The Journal has been much larger has contributed to our late issue. In 1944 there were 1,134 pages, in 1945, 1,428, and in 1946 there were 1,682. This does not include the four cover pages, nor the inserts. This is by far the largest Journal we have ever published, by over 15 per cent. This increase has been partly an increased amount of advertising, but not all.

We have continued to use in the front pages where most of the advertising appears an average of about fourteen pages of reading material such as Political Medicine, War Medicine, Readjustment For Veterans, Medical Public Relations, Medical Service Plans, and other articles of interest to the profession. This material is secured from various sources, but mostly by gleaning from our exchanges and the daily happenings that come to our attention. We have felt that this material was of great value to our members and we would like to con-

tinue it. The amount of such material could be lessened, but interspersing it among the advertising pages makes for more attractiveness to the advertisers and gives our members opportunities to follow the trends and thought of many of our contemporary editors.

During the year we have published sixty-five original articles, which we believe to be of high quality. There have been times when we wondered where we would secure sufficient papers, but they have continued to come, and our supply now on hand is sufficient for half the year 1947. With an annual session this year material has been abundant, and there have been many voluntary contributions.

Book Reviews.—With the shortage of paper, and so many doctors in military service we would not have been surprised if less books came for review, but that has not been the case. We have published seventy-five such reviews.

Editorials.—Sixty-four editorials have been published. These have ranged from socio-economic topics to New Year's greetings. We have been mostly interested in medical service, legislation, encroachment on our methods of life. We fear there has been some sameness to our efforts, but there has been an attempt to interpret the thoughts of The Council to our members, and we believe with some success.

For several years all editorials have been submitted to the Publication Committee, as was directed by The Council, and we are thankful for some keen and constructive criticism. We have also taken occasion at times to submit editorials to others who were especially interested in topics under discussion.

Deaths.—There have been fifty-two deaths recorded this year as against seventy-one in 1945 and sixty-eight in 1944.

We are proud to submit this report of a year's work which has been one of success and of accomplishment. Our part in it has been the making of the permanent record.

Respectfully submitted,

WILFRID HAUGHEY, M.D., *Editor.*

January 31, 1947

TREASURER'S ANNUAL REPORT—1946

The statement of securities and cash held by the Michigan State Medical Society as of December 31, 1946, is shown below.

Changes in bonds owned during the year were as follows:

Balance at December 29, 1945		$ 74,001.23
ADDITIONS:		
United States Savings Bonds purchased at issue price: (In 1946)		
Series G, 2½%, maturing May 1, 1958	$ 5,000.00	
Series G, 2½%, maturing Aug. 1, 1958	30,000.00	
Increase in redemption value on United States Savings Bonds acquired in prior years	421.70	35,421.70
		$ 109,422.93
DEDUCTIONS:		
Bonds called for redemption and surrendered for cash during the year:		
Union Pacific Railroad Company, 3½%, maturing October 1, 1970	$ 991.25	
Government of the Dominion of Canada, 3%, maturing January 15, 1967	947.50	
American Telephone and Telegraph Company, 3¼%, maturing December 1, 1966	2,060.00	
Consumers Power Company, 3¼%, maturing November 1, 1966	1,020.00	
	$ 5,018.75	
Bonds contributed to the Michigan Foundation for Medical and Health Education	21,544.03	26,562.78
Balance at December 31, 1946		$ 82,860.15
Interest on Securities		$ 1,611.70
Interest on Time Deposits		209.59
Gain on Bonds disposed of		203.75
Miscellaneous		3.00
Earnings on Bonds 45 to 46		$ 2,028.04
Cash balance in Bank from previous year		556.33
Cash balance in Michigan National Bank, Grand Rapids, as of December 31, 1946		$ 2,584.37
Market or Redemption prices of all Securities as of December 31, 1946		$ 81,817.40
Cash in Bank		2,584.37
Total actual worth at Market price of Bonds as of December 31, 1946, and including cash on hand		$ 84,441.77

Respectfully submitted,

A. S. BRUNK, M.D., *Treasurer*

SECURITIES AND CASH

Bonds held by Michigan State Medical Society for general purposes:	Interest Rate	Maturity	Interest Paid To	Principal Amount	Cost	Market or Redemption	Prices Dec. 31, 1946	Income from Dec. 29, 1945 To Dec. 31, 1946
Canadian Pacific Railway Company	4 %	Perpetual	July	1-1946	$ 2,000.00	$ 1,855.00	$ 2,100.00	$ 80.00
Detroit Edison Company	3½	Sept. 1-1966	Sept.	1-1946	2,000.00	2,187.50	2,175.00	70.00
Grand Rapids Affiliated Corporation	5	Oct. 1-1955	Oct.	1-1946	1,000.00	920.00	950.00	50.00
New York Central Railroad Company	4	Feb. 1-1998	Aug.	1-1946	2,000.00	1,173.75	1,515.00	80.00
United Light and Power Company	5½	Apr. 1-1959	Oct.	1-1946	1,000.00	925.00	1,030.00	55.00
Southern Pacific Company	4½	Mar. 1-1977	Sept.	1-1946	1,000.00	850.00	1,012.50	45.00
United States Savings Bond, Series G	2½	Jan. 1-1956	Dec.	1-1946	5,000.00	5,000.00	4,810.00	125.00
United States Savings Bonds, Series G	2½	Feb. 1-1957	Aug.	1-1946	17,600.00	17,600.00	16.473.00	440.00
United States Savings Bond, Series G	2½	June 1-1957	Dec.	1-1946	5,000.00	5,000.00	4,845.00	125.00
United States Savings Bond, Series G	2½	Dec. 1-1957	Dec.	1-1946	1,000.00	1,000.00	978.00	25.00
United States Savings Bonds, Series G-Note C	2½	May 1-1958	Nov.	1-1946	5,000.00	5,000.00	4,940.00	62.50
United States Savings Bonds, Series C	Note A	July 1-1947			7,500.00	7,200.00	7,200.00	300.00
United States Savings Bonds, Series D	Note A	Apr. 1-1949			1,300.00	1,170.00	1,170.00	39.00
United States Savings Bonds, Series F	Note A	May 1-1953			2,500.00	2,022.50	2,022.50	57.50
United States Savings Bonds, Series F	Note A	July 1-1953			700.00	557.90	557.90	14.70
United States Savings Bonds, Series F	Note A	Sept. 1-1953			500.00	398.50	398.50	10.50
					$ 55,100.00	$ 52,860.15	$ 52,177.40	
Bonds held by the Michigan State Medical Society for the Public Education Fund:								
United States Savings Bonds, Series G	2½	Aug. 1-1958			30,000.00	30,000.00	29,640.00	
					$ 85,100.00	$ 82,860.15	$ 81,817.40	

TRUSTEE'S ANNUAL REPORT—1946

Bonds in the Trustee Fund

BOND	Interest Rate	Date Due	Quoted Market Price Jan. 29, 1947
2 M New England Gas and Electric	5	1950	$ 2,000.00
1 M Southern Pacific Railroad	4½	1977	1,020.00
1 M Grand Rapids Affiliated	5	1955	950.00
Total Market Value of Bonds			$ 3,970.00

CASH ACCOUNT

Balance on hand January 1, 1946	$ 919.40
Collected in interest from January 1, 1946 to January 1, 1947	195.00
Balance on hand January 29, 1947, in Michigan National Bank	$ 1,114.40

January 31, 1947

Respectfully submitted,
WM A. HYLAND, M.D., *Trustee.*

BUDGETS—1947

GENERAL FUND

INCOME	1947
4,000 Members at $12 (dues)	$ 48,000.00
Less Allocation to JOURNAL at $1.50	6,000.00
	$ 42,000.00
Interest Income	1,000.00
Miscellaneous Income	100.00
TOTAL INCOME	$ 43,100.00
From RESERVES	10,905.00
	$ 54,005.00

APPROPRIATIONS	
Administrative and General	
Administrative Salaries	$ 6,000.00
Salaries—Office and General	5,580.00
General Counsel	2,500.00
General Counsel Expense	1,000.00
Office Rent and Light	1,650.00
Printing, Stationery, Supplies	1,500.00
Postage	1,000.00
Insurance and Fid. Bonds	1,650.00
Auditing	700.00
New Equipment and Repairs	750.00
Telephone and Telegraph	1,500.00
Payroll Social Security Taxes	200.00
Unemployment Compensation Taxes	750.00
Miscellaneous General Expense	100.00
	$ 24,880.00
Society Activity	
Council Expense	$ 5,000.00
Delegates to AMA	2,000.00
General Society Travel	1,500.00
Officer's Travel	1,500.00
Secretary's Letter	1,500.00
Legal Expense	6,000.00
Woman's Auxiliary—Annual Meeting	200.00
Sundry Society Expense	150.00
	$ 17,850.00
Committee Expense	
Legislative Com.	$ 1,000.00
Dist. of Med. Care	150.00
P.G. Medical Education	3,500.00
Preventive Medicine	100.00
Cancer Committee	5,000.00
Child Welfare	50.00
Iodized Salt	50.00
Heart and Deg. Diseases	50.00
Ind. Health Com.	50.00
Maternal Health	50.00
Mental Hygiene	75.00
Scientific Radio	50.00
Venereal Disease Control	150.00
Tuberculosis Control	50.00
Ethics	50.00
Commission on Health Care	300.00
Scientific Work	50.00
Prelic. Medical Education	50.00
Sundry other Committees	500.00
	$ 11,275.00
GRAND TOTAL	54,005.00
GAIN OR LOSS	$ 10,905.00

THE JOURNAL

INCOME	
Subscriptions (4,000 at $1.50)	$ 6.000.00
Other subscriptions	100.00
Advertising Sales	31,300.00
Reprint Sales and Cuts	1,600.00
TOTAL INCOME	$ 39,000.00

EXPENSES	
Salaries	$ 7,200.00
Editor's Expense	1,200.00
Printing and Mailing	22,000.00
Reprint and Cut Expense	1,400.00
Disc. & Com. on Adv. Sales	7,000.00
Miscellaneous JOURNAL Expense	200.00
	$ 39,000.00

PUBLIC EDUCATION

INCOME	
Reserve, Dec. 31, 1946 (Including $30,000.00 in Government Bonds)	$ 48,614.02
Estimated Income from Assessment (4,000 at $25.00)	$ 100.000.00
TOTAL	$ 148,614.02

EXPENSES	
Salaries	$ 9,860.00
Rent	480.00
Telephone and Telegraph	750.00
Printing, Stationery, Supplies	2,500.00
Postage	1,500.00
New Equipment	1,125.00
Travel	1,475.00
P.R. & Secy. Conferences	2,350.00
Purchase of Pamphlets for	
(a) Public	3,200.00
(b) Profession	2,100.00
(c) Civic Groups	1,600.00
(d) Schools	2,200.00
Michigan Health Council	5,000.00
National Conf. on Med. Service	500.00
Committee Meetings	1,100.00
Newspaper	34,000.00
Radio	15,000.00
School Program	4,000.00
Display	1,500.00
Cinema	1,000.00
Journal	2,000.00
Miscellaneous	950.00
Conf. of Presidents	250.00
Total Estimated Expenses	$ 94,440.00
Reserve (Including $30,000 in Gov't. Bonds)	49,174.02
	$ 148,614.02

REPORT OF ERNST & ERNST—1946

We have examined the balance sheet of the Michigan State Medical Society as of December 31, 1946, and the statements of income and expense and surplus for the period from December 29, 1945, to December 31, 1946, have reviewed the system of internal control and the accounting procedures of the Society and, without making a detailed audit of the transactions, have examined or tested accounting records of the Society and other supporting evidence, by methods and to the extent we deemed appropriate. Our examination was made in accordance with generally accepted auditing standards applicable in the circumstances and included all procedures which we considered necessary.

The Society was organized on September 17, 1910, under the laws of the State of Michigan as a corporation not for pecuniary profit. The charter was extended on November 10, 1941, for a period of thirty years from September 17, 1940. The Society is affiliated with the American Medical Association and it charters county medical societies within the State of Michigan. The purposes of the Society are the promotion of the science and art of medicine, the protection of the public health, and the betterment of the medical profession. In the furtherance of these purposes the Society publishes THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY.

Balance Sheet

The balance sheet at December 31, 1946, is summarized as follows:

ASSETS

Cash	$ 64,474.81
Accounts receivable, less reserve	11,427.97
Securities—at cost	82,860.15
Bonds and cash for Postgraduate Medical Education Foundation	
	$158,762.93

Liabilities	
Accounts payable	$ 18,218.68
Unearned income	17,138.00
Reserve for Postgraduate Medical Education Foundation	
Reserves for unexpended funds received for special purposes	51,021.99
Surplus	72,384.26
	$158,762.93

Income and Expense Statement

A summary of the income and expense statement for the period from December 29, 1945, to December 31, 1946, is presented as follows:

Income	
Membership fees	$42,958.19
Income from The Journal	9,404.26
Interest received	1,821.29
Gain (loss) on disposal of bonds	203.75
Recovery of funds advanced to Michigan Medical Service	
Miscellaneous	3.00
Total Income	$54,390.49
Expenses	
Administrative and general	$24,818.71
Society activities	11,645.81
Annual session	1,022.04
Committee expenses	5,979.94
Total Expenses	$43,466.50
Net Income	$10,923.99

Accounts Receivable

Accounts receivable as of December 31, 1946, for advertising, were analyzed as to period of charge and are shown as follows:

Period of Charge	*Amount*	*Per Cent*
October, November, and December	$3,805.55	95.88%
July, August, and September	85.00	2.14
January to June, inclusive	78.72	1.98
Total	$3,969.27	100.00%

Our examination of accounts receivable as of December 31, 1946, included tests of the balances by communication with selected debtors. It is our opinion that the reserve of $100.00 is sufficient for losses in collection of the accounts.

Securities

The changes in bonds owned during the year were as follows:

Balance at December 29, 1945		$ 74,001.23
Additions		
United States Savings Bonds purchased at issue price:		
Series G, 2½%, maturing May 1, 1958	$ 5,000.00	
Series G, 2½%, maturing August 1, 1958	30,000.00	
Increase in redemption value of United States Savings Bonds acquired in prior years	421.70	35,421.70
		$109,422.93
Deductions		
Bonds called for redemption and surrendered for cash during the year:		
Union Pacific Railroad Company, 3½%, maturing October 1, 1970	$ 991.25	
Government of the Dominion of Canada, 3%, maturing January 15, 1967	947.50	
American Telephone and Telegraph Company, 3¼%, maturing December 1, 1966	2,060.00	
Consumers Power Company, 3¼%, maturing November 1, 1966	1,020.00	
	$ 5,018.75	
Bonds contributed to the Michigan Foundation for Medical and Health Education	21,544.03	26,562.78
Balance at December 31, 1946		$ 82,860.15

Represented by:

Bonds held by the Society for general purposes	$ 52,860.15
Bonds held by the Society for the Michigan State Medical Society Public Education Fund	30,000.00
Balance at December 31, 1946	$ 82,860.15

Bonds owned at December 31, 1946, have been stated at cost, adjusted for increases in redemption value of United States Savings Bonds. We inspected the bonds held by the Society and accounted for the income from all bonds for the period. At December 31, 1946, the aggregate cost of the bonds held by the Society was $1,042.75 in excess of the aggregate market or redemption price.

During the period, pursuant to a resolution adopted by the Executive Committee in its session of October 18, 1945, the assets, consisting of cash and bonds, relating to the Postgraduate Medical Education Foundation, were transferred to a newly organized non-profit corporation, Michigan Foundation for Medical and Health Education. The final income and expense statement of the old Medical and Health Education program is included with this report.

In accordance with a resolution adopted by the Executive Committee in its meeting of September 26, 1946, the Society has set aside United States Savings Bonds, Series G, maturing August 1, 1958, in the principal amount of $30,000.00 for the use of the Michigan State Medical Society Public Education Fund.

The Society has continued its policy of waiving payment of dues by members in military or naval service and, in the event the dues were paid for the year of induction, to allow free membership for a designated period following discharge. Because the fiscal period ended December 31, 1946, represents this designated period for the majority of such members, the Society has transferred to income for the period ended December 31, 1946, a portion of such dues which had been classified as unearned income when received. The amount of $9,300.00 so transferred was allocated to membership fees ($8,137.50) and to income of The Journal ($1,162.50). The balance of $4,800.00 in this account at December 31, 1946, is sufficient to provide for dues of members now in, or recently discharged from, the armed services who entered service as currently paid-up members of the Society.

A statement of the income and expenses of the Public Education program conducted by the Society is included in this report. The unexpended balance of funds assessed for this purpose has been reflected as a reserve in the accompanying balance sheet.

During the period, the Society received a contribution of $15,000.00 from the The Michigan Society for Crippled Children and Disabled Adults to be used in the furtherance of the Society's rheumatic fever program. Pursuant to a directive of The Council in its annual meeting of January 18, 1946, these funds have been segregated from the general funds of the Society. A statement of the income and expenses of the Committee on Rheumatic Fever Control is included in this report. The unexpended balance of these funds has been reflected as a reserve in the accompanying balance sheet.

BALANCE SHEET—December 31, 1946

Assets

Cash		
Demand deposits (including $7,407.97 designated for Committee on Rheumatic Fever Control)	$51,019.84	
Office cash fund	.92	
Savings deposits	13,454.05	$ 64,474.81
Accounts Receivable		
Advertising	$ 3,969.27	
Space at 1947 annual session	7,407.50	
State pay roll taxes overpaid	151.20	
	$11,527.97	
Less reserve	100.00	11,427.97
Securities—at cost (aggregate market or redemption price $81,817.40)		
United States Savings Bonds	$74,948.90	
Other bonds	7,911.25	82,860.15
		$158,762.93

Liabilities

Accounts Payable		
Current expenses and miscellaneous liabilities	$18,102.41	
Pay roll taxes	116.27	$ 18,218.68
Unearned Income		
Dues for the year 1947	$ 2,003.00	
Space sales for 1947 annual session	10,335.00	
Dues of members in armed services applicable to a future year	4,800.00	17,138.00
Reserves—for unexpended funds received for special purposes		
Public Education Program	$43,614.02	
Rheumatic Fever Control Program	7,407.97	51,021.99
Surplus		
Balance at December 29, 1945	$61,460.27	
Net income for the pariod from December 29, 1945, to December 31, 1946	10,923.99	72,384.26
		$158,762.93

INCOME AND EXPENSE STATEMENT

From December 29, 1945, to December 31, 1946

Income		
Membership fees	$39,760.19	
Income transferred from dues of military members deferred in prior years	9,300.00	
	$49,060.19	
Less portion allocated to income of The Journal for subscriptions	6,102.00	$ 42,958.19
Income from The Journal		9,404.26
Interest:		
On securities	$ 1,611.70	
On time deposits	209.59	1,821.29
Gain on disposal of bonds		203.75
Miscellaneous income		3.00
TOTAL INCOME		$ 54,390.49
Expenses		
Administrative and general	$24,818.71	
Society activities	11,645.81	
Annual session	1,022.04	
Committee expenses	5,979.94	43,466.50
NET INCOME		$ 10,923.99

Transactions of the Public Education Fund and the Committee on Rheumatic Fever Control, which do not affect net income for the year, are not included in this statement but are shown in separate statements included hereinafter.

INCOME AND EXPENSE OF PUBLIC EDUCATION PROGRAM

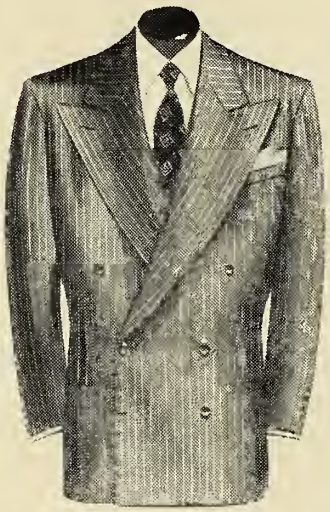
From December 29, 1945, to December 31, 1946

Balance of unexpended funds at December 29, 1945, as reflected in reserve		$ 12,150.00
Income from assessment of the membership		82,344.00
Expenses		
Salaries	$ 6,362.82	
Radio programs	18,156.98	
Michigan Health Council	5,000.00	
School of information	1,938.07	
Newspaper programs	5,334.90	
Purchase of pamphlets	5,549.60	
Rent	70.00	
Telephone and telegraph	630.69	
Printing, stationery, and supplies	2,341.79	
Postage	1,187.82	
Office equipment	554.71	
Travel expenses	1,323.40	
Conference of presidents	172.17	
National conference of medical service	329.78	
Committee meetings	679.05	
Child health survey	1,000.00	
Miscellaneous	248.20	
		$ 50,879.98
Net Income		$ 31,464.02
Balance of unexpended fund at December 31, 1946, as reflected in reserve		$ 43,614.02

INCOME AND EXPENSES OF RHEUMATIC FEVER CONTROL PROGRAM

Period ended December 31, 1946

Grant from The Michigan Society for Crippled Children and Disabled Adults		$ 15,000.00
Expenses of central office:		
Salaries	$ 816.25	
Equipment and repairs	603.77	
Supplies	130.75	
Pay roll taxes	15.60	
Committee meeting expense	197.41	
		$ 1,763.78
Expenses of local consultation and diagnostic centers:		
Ann Arbor	250.00	
Bay City	1,250.00	
Flint	.....	
Grand Rapids	1,262.00	
Jackson	250.00	
Kalamazoo	250.00	
Lansing	816.25	
Marquette	1,000.00	
Traverse City	750.00	
		$ 5,828.25
Total Expenses		$ 7,592.03
Net Balance as reflected in reserve at December 31, 1946		$ 7,407.97



Report on the Suit Situation

We wouldn't go so far as to say our selection of suits is as complete as it has been in seasons long past . . . but the selection we now offer is the best we have had in many a day. Choice woolens, a good range of patterns . . . styled in the customary whaling manner. And, as always, our skilled custom fitting. From $60.00.

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INCOME FROM "THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY"

From December 29, 1945, to December 31, 1946

Income	
Subscriptions from members	$ 6,102.00
Other subscriptions	278.27
Advertising sales	52,006.41
Reprint sales	2,136.83
Journal cuts	224.75
	$ 60,748.26
Expenses	
Salaries	$ 7,667.50
Editor's expenses	1,226.65
Printing and mailing	25,249.06
Cost of reprints and cuts	1,908.68
Discounts and commissions on advertising sales	13,198.02
Allocation of administrative and general expense	1,800.00
Miscellaneous	294.09
	$ 51,344.00
Net Income	$ 9,404.26

GENERAL SOCIETY EXPENSES

From December 29, 1945, to December 31, 1946

Administrative and General	
Salaries—administrative	$ 7,500.00
Salaries—office	5,301.00
General counsel	3,774.47
Office rent and light	1,341.00
Printing, stationery, and supplies	1,993.39
Postage	1,071.98
Insurance and fidelity bonds	1,659.08
Auditing and system service	692.50
Repairs	426.85
Telephone and telegraph	1,712.40
Michigan sales tax	19.23
Pay roll taxes	909.49
Miscellaneous	217.32
	$ 26,618.71
Less expenses redistributed to The Journal	1,800.00
	$ 24,818.71
Society Activities	
Council expense	$ 4,952.27
Delegates to American Medical Association	3,015.21
County Secretaries' Conference	.....
General society travel expenses	893.38
Officers' travel expenses	874.89
Secretary's letters	1,513.70
Publication expense	10.65
Legal expense	35.00
Women's auxiliary—annual session	200.00
Sundry society expense	150.71
	$ 11,645.81
Annual Session	
Salaries	$ 4,140.00
Reporting	178.05
Other expenses	8,073.99
	$ 12,392.04
Less sales of display space	11,370.00
	$ 1,022.04
Committee Expenses	
Legislative	$ 433.69
Distribution of medical care	40.55
Postgraduate medical education	3,515.91
Preventive medicine	117.86
Cancer control	332.48
Child welfare	94.66
Industrial health and clinic	164.67
Mental hygiene	11.00
Venereal disease control	66.42
Scientific work	54.46
Procurement and assignment of doctors of medicine	24.30
Prelicensure medical examination	368.33
Postgraduate clinical conference	115.20
Sundry other committees	640.41
	$ 5,979.94
TOTAL	$ 43,466.50

Opinion

In our opinion, the accompanying balance sheet and related statements of income and expense present fairly the position of Michigan State Medical Society at December 31, 1946, and its income and expenses for the period from December 29, 1945, to December 31, 1946, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding period.

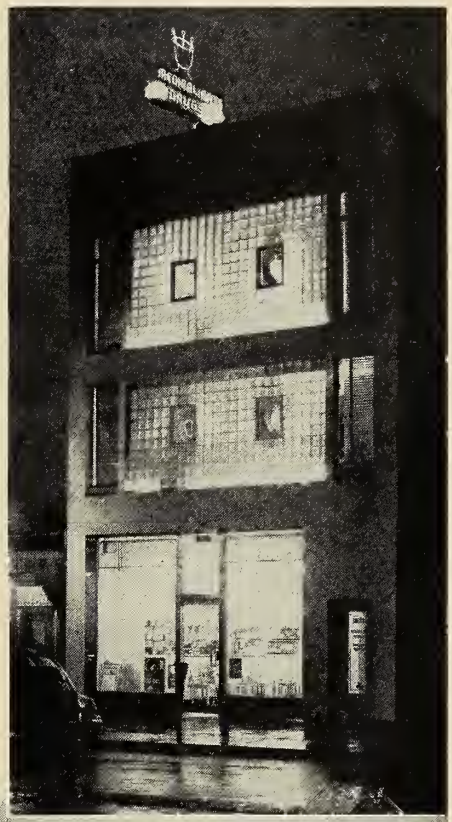
Ernst & Ernst
Certified Public Accountants

January 31, 1947

The Most Modern Prescription Pharmacy in Michigan

THREE FLOORS OF PRESCRIPTION NEEDS AND PHYSICIAN'S SUPPLIES

Medical Arts Pharmacy represents the achievement, through the physician's co-operation, of one of the finest and most modern of professional prescription pharmacies in Michigan. Established in 1936 it has had a phenomenal growth through strict adherence to the highest of ethics. *"Nothing Sold Without a Doctor's Prescription"* has been the policy since the inception of Medical Arts Pharmacy and it continues to be rigidly maintained to this day.



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Your Supplier of All New Drugs From All Over the World

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Woman's Auxiliary

MID-YEAR BOARD MEETING

The mid-year Board meeting of the Woman's Auxiliary to the Michigan State Medical Society was held at the Hayes Hotel, Jackson, Michigan, on January 8, 1947. Following a luncheon served to twenty-three members of the Board of Directors, the business was presented.

The treasurer's report showed a balance in the checking account of $1,502.64; total assets including bonds, $2,829.64. An invitation to representatives of the Woman's Auxiliary to attend the Annual County Secretaries' Conference, February 2, in Detroit, was read.

A letter from Mr. Hugh W. Brenneman, Public Relations Counsel, recommended "that county medical societies be urged to award honorary membership to outstanding friends of the medical profession in the community, such as newspapermen, civic leaders, et al. This same project could be followed up by the Woman's Auxiliary." Motion was made and seconded to follow the directive of the State Medical Society in regard to the recommendation. This is a splendid opportunity for an outstanding Public Relations meeting. Consult with your Medical Society in making plans.

Reports of the National Board Conference held in Chicago were given by the president and president-elect, Mrs. Grover T. Amos. Three past presidents commented on Auxiliary activities—Mrs. Glen Hicks, Jackson, Mrs. Lloyd Harvie, Saginaw, and Mrs. Horace French, Lansing.

Mrs. Bruce Macduff, Legislative chairman, suggested that members express themselves as citizens of their communities rather than as doctors' wives. She offered to visit county meetings. Mrs. Leonard Himler, organization chairwoman, reported forty-three organized counties, forty unorganied. She suggested members of unorganized areas be invited to attend meetings of organized groups. Mrs. H. P. Kooistra, program chairman, and Mrs. Frederick Pietz, public relations chairman, stated that letters and material had been sent to all local chairmen. Mrs. Milton Shaw, chairman of the tuberculosis-speaking project, gave a detailed report of the project. It was moved and seconded to continue this project for the coming year. Mrs. MacCallum, press chairman, noted that only four counties had sent in material. County reports brought out many varied activities and much enthusiasm.

The Nominating Committee was appointed as follows: Mrs. Horace French, chairman, Mrs. Lloyd Harvie, and Mrs. Floyd Gibbs.

Motion was made and seconded to publish a spring issue of the *Auxiliary News,* if there is sufficient material.

Mrs. George M. Baker extended an invitation to tea, on behalf of the Jackson County Auxiliary, immediately following the meeting.

STATE AND NATIONAL MEETINGS

The State Auxiliary convention will be held this year in Grand Rapids, September 23-26. Make your plans to attend now. The national convention will be held in Atlantic City, June 9-13. Notify your president if you plan to attend.

Vernor's

GINGER ALE

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Invigorating

Vernor's is used in leading hospitals in Michigan. Many patients find it refreshing and revitalizing. Occasionally it has been used to increase the caloric value of a diet.

A PREFERRED BEVERAGE FOR HOME AND HOSPITAL

to combat

depression characterized by

"chronic fatigue"

Depressed patients ". . . suffering from psychomotor inhibition complain of feeling tired, of not being able to get started on their daily tasks, and of an abnormal inclination to procrastinate. They make up their minds that they are going to do a certain thing but they never seem to get to it. Everything seems too big for them . . ."*

In the above quotation, Kamman emphasizes "chronic fatigue" as a dominant symptom in the type of depression most frequently encountered in daily practice.

Benzedrine Sulfate is particularly valuable in the presence of "chronic fatigue". It will, in most cases, help to overcome the depression and thus enable the patient to make a sincere and constructive effort to surmount his difficulties.

*Kamman, G. R.: Fatigue as a Symptom in Depressed Patients, Journal-Lancet 65:238 (July) 1945.

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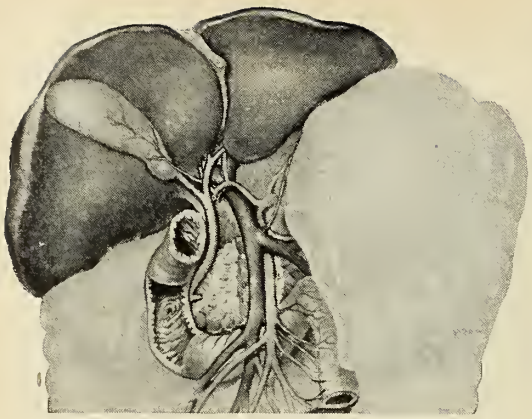
benzedrine sulfate

(*racemic amphetamine sulfate, S.K.F.*)

Smith, Kline & French Laboratories, *Philadelphia, Pa.*



In Cholangitis . .

Decholin produces hydrocholeresis, flushing the bile ducts, removing accumulated mucus and inspissated bile.

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Decholin relieves stasis, discourages ascending infection, promotes drainage.

In Biliary Surgery . .

Decholin fits well into the post-operative routine by materially helping to keep the bile passages free from offending debris.

HOW SUPPLIED: *Decholin* in 3¾ gr. tablets. Boxes of 25, 100, 500 and 1000.

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(dehydrocholic acid)

AMES COMPANY, Inc.

Successors to Riedel-de Haen, Inc.

ELKHART, INDIANA

In Memoriam

Gordon G. Feldman, M.D., Yale, was born in Paonia, Colorado, on June 23, 1898; received his doctor of medicine degree in 1932 from the University of Nebraska. He had practiced in Yale since 1943. Doctor Feldman died in Yale, January 24, 1947.

* * *

John H. Law, M.D., Detroit, was born in Detroit and graduated from the University of Michigan Medical School. He was a former president of the Michigan Hospital Association, and at the time of his death was director of Grace Hospital, Detroit. Doctor Law died in Detroit on January 9, 1947.

* * *

M. M. Marrin, M.D., Grand Rapids, was born in Grand Rapids on May 23, 1906; graduated from the University of Michigan Medical School in 1932; practiced in Grand Rapids until his death except for the period of his military service from March, 1941, to November, 1945. Doctor Marrin entered the army medical corps as a First Lieutenant and rose to the rank of Colonel commanding the 237th General Hosiptal during its tour of duty in France. Doctor Marrin died suddenly in Grand Rapids on February 8, 1947.

* * *

Albert E. Stickley, M.D., Coopersville, was born September 3, 1873, in Muskaka, Canada; was graduated from the Grand Rapids Medical College; served in the medical corps in the Spanish-American War and was a captain in the medical corps in World War I. He had practiced for the past twenty-seven years in Coopersville. Doctor Stickley died in Muskegon on January 23, 1947.

* * *

NEW CONCEPTS OF THE CAUSES OF ASTHMA

(Continued from Page 329)

onset is vital, and the episodes in asthma must in each case be correlated with other episodes in the patient's life, with changes in his environment or his occupation, intercurrent diseases, operations, marriage, et cetera. Any one or all of these things may be important, and when recorded with the asthma, a crossed relation is frequently observed. The concept of "depletion" appears to be of great practical importance in the clinic. It may be psychic or somatic, or both. The treatment of the patient as a whole is usually more important than the treatment of his asthma.

Say you saw it in the Journal of the Michigan State Medical Society

An Indispensable Diagnostic Aid

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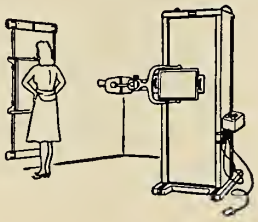

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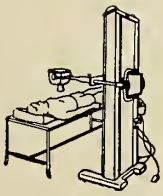
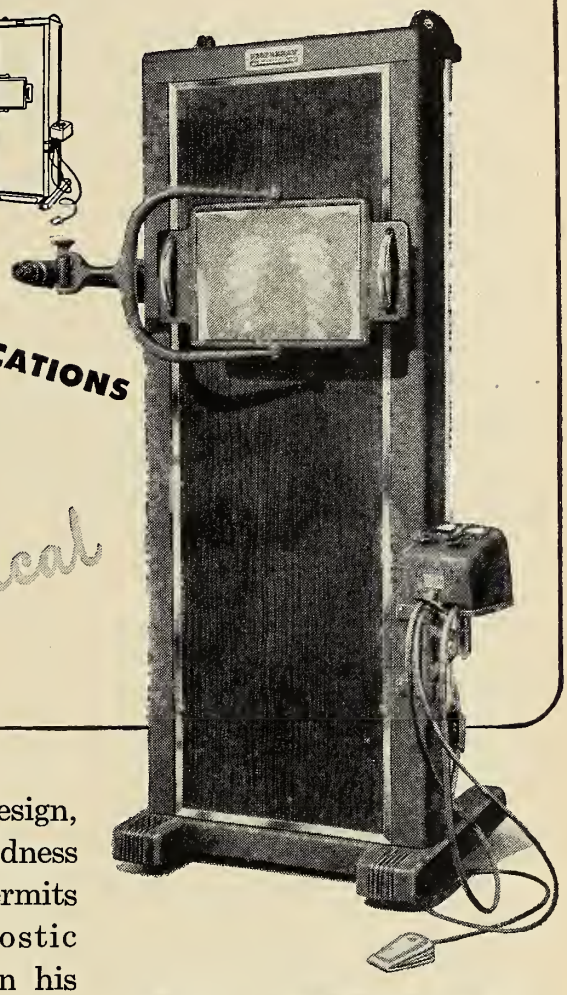
Efficient



Economical



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Michigan's Department of Health

Wm. De Kleine, M.D., Commissioner, Lansing, Michigan

RAPID TREATMENT CENTER HAS PEAK LOAD

The number of patients receiving treatment for venereal disease at the Michigan Rapid Treatment Center reached an all-time high of 159 on January 15, 1947. Up to the first of the year, 6,279 cases were treated at the Center since its establishment in July, 1944. About 95 per cent were syphilis. There were 3,487 male patients and 2,792 female.

INCIDENCE OF COMMUNICABLE DISEASES

Disease	Jan. 1947	Jan. 1946	7-year Median
Diphtheria	42	48	27
Gonorrhea	983	1,285	595
Lobar pneumonia	102	127	306
Measles	204	2,451	1,384
Meningococcic meningitis	5	34	24
Pertussis	922	466	466
Poliomyelitis	16	5	4
Scarlet fever	570	543	944
Syphilis	1,277	1,427	909
Tuberculosis	385	310	329
Typhoid fever	1	4	3
Undulant fever	8	7	8
Smallpox	0	0	1

SHORTAGE OF PUBLIC HEALTH NURSES

Michigan has an average of one public health nurse to about 6,700 people. In some parts of the state one public health nurse must serve 10,000, 15,000 and sometimes 20,000 persons. Authorities recommend that one public health nurse serve a maximum population of 5,000. Latest count of public health nurses employed in Michigan is 815, but to provide minimum service, this number should be at least 1,090.

NEWS OF PERSONNEL

William J. Morrow, M.D., joined the staff of the Department's Bureau of Maternal and Child Health on January 13, 1947, as a pediatric consultant. He will alternate for periods of about three months as field pediatric consultant with the Department and as instructor in the Pediatric Department and instructor in postgraduate education at the University of Michigan.

Dr. Morrow is a graduate of the University of Michigan Medical School and served his internship at City Hospital and Babies' and Children's Hospital in Cleveland, Ohio. Since 1944, he has been resident physician at the Children's Memorial Hospital, Chicago, and during the past year he was instructor in pediatrics.

DR. VAUGHAN RE-ELECTED COUNCIL PRESIDENT

Henry F. Vaughan, Dr. P.H., Ann Arbor, was re-elected president of the State Council of Health at a meeting of the Council in Ann Arbor, January 17, 1947. C. L. Hess, M.D., Bay City, was elected vice president, a new Council position.

VARICOSE VEINS

(Continued from Page 324)

been healed, the patient should gradually be returned to normal ambulation with the use of elastic stockings or any type of pressure bandage. Careful re-examination at this time will enable the physician to assess accurately the extent of vascular disease and to determine whether or not it is amenable to surgical treatment. The patency of the deep circulation must be constantly kept in mind.

Calcification in long standing varices is often seen and presents something of a problem for treatment. Obviously these veins cannot be collapsed, and satisfactory obliteration is almost impossible. Excision is the only logical treatment. It should not be forgotten that further dilatation is unlikely to occur when the walls are calcified and that treatment may not be necessary unless the impaired circulation is producing complications.

At the completion of treatment, the patient should be informed of the tendency for other varicosities to develop and should be advised to return when these first become apparent. He will usually be glad to do this if he realizes that a few simple injections will probably be all the treatment required. This will also help the physician to follow up his cases and evaluate results.

In conclusion, it is deemed advisable to stress the importance of individualizing each case and to emphasize careful evaluation of the underlying pathologic anatomy. Very few cases will be encountered which will not be benefited by logical and meticulous treatment.

Optimum Protection

Ramses
PRESCRIPTION PACKET
NO. 501

1. Extensive clinical experience has established that the combined use of an occlusive diaphragm and a spermatocidal jelly affords the optimum in protection to the patient.

2. A comprehensive report shows an overwhelming preference for the diaphragm-jelly technique of conception control. In a survey comprising 36,955 cases, clinicians prescribed this method for 34,314 or 93 per cent.[1]

3. Warner,[2] in a study of 500 cases in private practice, concludes that the combined technique is the most efficient method; there was no case of unexplained failure.

4. For the optimum of protection and simplicity in use we suggest the "RAMSES" Prescription Packet NO. 501 . . . a complete unit, containing a "RAMSES" Patented Flexible Cushioned Diaphragm of prescribed size, a "RAMSES" Diaphragm Introducer of corresponding size, and a large tube of "RAMSES" Vaginal Jelly.† Available through all prescription pharmacies. Complete literature to physicians on request.

[1]Human Fertility 10: 25 (Mar.) 1945.

[2]Warner, M. P.: J.A.M.A. 115: 279 (July 27) 1940.

gynecological division

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What's What

Renew your federal narcotic license on or before July 1, 1947. Send application blank and check to the Federal Narcotic Agent, Federal Bldg., Detroit, Michigan.

* * *

C. C. Sturgis, M.D., Ann Arbor, is the author of an original article on "Hemotology" which appeared in *JAMA,* December 21, 1946.

* * *

LeMoyne Snyder, M.D., J.D., and Wm. J. Burns, LL.B., both of Lansing, have been appointed by President Laurent K. Barnum, Grand Rapids, as members of the Committee on Medical Jurisprudence of the State Bar of Michigan.

* * *

Jottings: A bill to curb grand juries by disqualifying grand jurors from sitting as examining magistrates in their own cases is in the Michigan House of Representatives. . . . Application forms for veterans' bonuses payments will be available by March 15.

* * *

"Influence of Nephrectomy on Hypertension" is the title of an original article by Rigdon K. Ratliff, M.D., Reed M. Nesbit, M.D., Robert T. Plumb, M.D., and Wait Bohne, M.D., of Ann Arbor, Michigan, which appeared in JAMA of February 1, 1947.

Army Day will be held on April 7, sponsored nationally by the Military Order of the World Wars. But this year Army Week will extend from April 6 through April 12, to focus public attention on the Army in order to develop public support and understanding of its peacetime assignments.

* * *

The Third American Congress on Obstetrics and Gynecology will be held in St. Louis, September 8-12, 1947. For copy of the scientific program, write the Congress at 24 W. Ohio St., Chicago 10, Illinois. J. P. Pratt, M.D., Detroit, is chairman of the scientific and educational exhibits.

* * *

O. E. Madison, Ph.D., Detroit, president of the American Association of Basic Science Boards, and chairman of the Michigan Basic Science Board, spoke on "A Proposed Uniform Basic Science Law" at the 43rd Annual Congress on Medical Education and Licensure, sponsored by the AMA in Chicago, February 10, 1947.

* * *

The City of Bessemer, with a population of 4,500 (Gogebic County, Upper Peninsula of Michigan), needs a doctor of medicine. Service to the minors guarantees

(Continued on Page 358)

Strict Attention to Each Prescription

ARTIFICIAL LIMBS

A complete selection and choice of latest refinements

ORTHOPEDIC BRACES

Constructed in our modern shop by skilled mechanics with many years experience

SURGICAL GARMENTS

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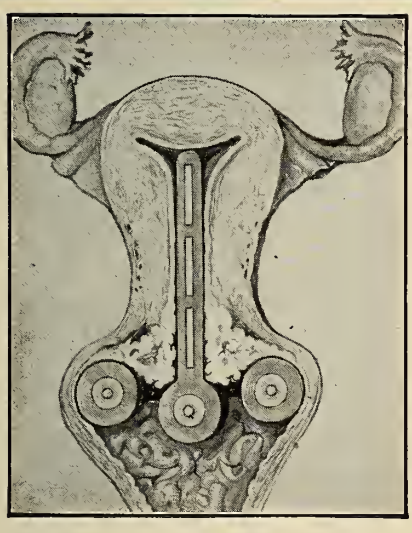

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(Continued from Page 356)

approximately $300 to $350 per month income, with opportunity for additional income from private practice. For details contact Walter Gries of Negaunee, Michigan.

* * *

The Phi Beta Pi Medical Fraternity Quarterly for January, 1947, contains a full-page picture of William A. Hyland, M.D., F.A.C.S., president of the Michigan State Medical Society. This same number similarly honors the presidents of Louisiana and Tennessee State Medical Societies, Valentine H. Fuchs, M.D., and Charles M. Hamilton, M.D.

* * *

Wm. J. Burns, Executive Secretary, Michigan State Medical Society, addressed the Michigan State Pharmaceutical Association at its ninth annual mid-season meeting in Lansing, January 23. His subject was "Progress Under the Veterans Administration—Michigan Medical Service Program for Medical, Dental, and Pharmaceutical Care to Veterans."

* * *

Your Foundation Goes on Record.—A brochure, "Leading in Learning," prepared by the Michigan Foundation for Medical and Health Education, explaining its purposes and proposals will be sent soon to each MSMS member. All are urged to show it to their friends and acquaintances. Additional copies may be procured from 2020 Olds Tower, Lansing 8, Michigan.

* * *

Questionnaire on Medical Care of Civilians during World War II. Have you executed the questionnaire, recently sent you by the National Emergency Medical Service Committee of the AMA, and returned it to 535 N. Dearborn Street, Chicago 10, Illinois?

Additional copies of the questionnaire are available by writing the AMA in Chicago or the MSMS at 2020 Olds Tower, Lansing 8, Michigan.

* * *

E. F. Sladek, M.D., Traverse City, chairman of The Council of the Michigan State Medical Society, was honored by being elected secretary of the National Conference on Medical Service, at its 1947 meeting in Chicago. Dr. Sladek and the Michigan State Medical Society were "hosts" to the National Conference on Medical Service at its 21st annual session at the Palmer House, Chicago, on Sunday, February 8, 1948.

* * *

A "friendly suit" to obtain an official interpretation of the sales tax diversion amendment will be filed in the Supreme Court by the Michigan Education Association. When he heard the news, Attorney General Black announced, "There will be nothing friendly about such a suit. When someone plans to tap the state for several millions in taxpayers' money, I'm going in their to fight." —*Michigan Survey,* February 17, 1947.

* * *

Advisory Committee to the Bureau of Maternal and Child Welfare, Michigan Department of Health. The personnel of the Advisory Committee, appointed at the request of the State Department of Health, is as fol-

(Continued on Page 360)

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(Continued from Page 358)

lows: Frank VanSchoick, M.D., Jackson, Chairman, A. E. Catherwood, M.D., Detroit, Campbell Harvey, M.D., Pontiac, Wilfrid Haughey, M.D., Battle Creek, Harold Henderson, M.D., Detroit, W. G. Hoebeke, M.D., Kalamazoo, R. M. Kempton, M.D., Saginaw, S. L. Loupee, M.D., Dowagiac, R. H. Pino, M.D., Detroit, and P. W. Willits, M.D., Grand Rapids.

* * *

Michigan Hospital Service, on December 31, 1946, showed a reserve for contingencies amounting to $815,188.83, a jump of over twice the sum in the reserve column as of the end of the preceding year.

Among operating statistics, the following extremely gratifying information is contained: Paid or obligated to hospitals, 78.22 per cent of income; net operating expenses, 7.90 per cent; contingency reserves, 13.88 per cent.

The administrative expenses are indeed low, and the reserves for emergencies are extremely generous.

* * *

Federal Interference.—The Study Commission appointed in January by Governor Sigler to investigate the Michigan Unemployment Compensation Commission reported the following choice item, among other criticisms of the MUCC:

"The Federal Social Security Board has 'persisted in interfering with' the MUCC, exceeding its authority," according to a report in the *Detroit Free Press* of February 16.

Would a similar situation exist if national health were entrusted into the hands of the Federal Social Security Board?

* * *

State Medical Society Dues.—Forty-eight states reported to the AMA on their dues, as the result of a recent survey. The following table shows the distribution by states and amount:

Annual Dues	Number of States
$ 5.00	3
7.00	1
8.00	1
10.00	7
12.00	2
15.00	9
20.00	6
25.00	7
30.00	2
33.00	1
35.00	2
37.00	1
40.00	2
50.00	3
100.00	1

* * *

The Calhoun County Medical Society and the Calhoun County Cancer Society sponsored the following educational program for the advancement of the study and control of cancer, which was held at Battle Creek on April 1, 1947. "Carcinoma of Uterus, Ovaries and Cervix" by Richard TeLinde, M.D., Professor of Gynecology, Johns Hopkins University Medical School, Baltimore, and "Carcinoma of Skin" by Louis A. Brunsting, M.D., Department of Dermatology, Mayo Clinic, Rochester, Minnesota, provided the afternoon talks. Stanley T. Lowe, M.D., President of the Calhoun County Medical Society, presided. Hugh J. Robbins, M.D., President of

(Continued on Page 362)

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(Continued from Page 360)

the Calhoun County Cancer Society presided at the evening session which was addressed by Grover C. Penberthy, M.D., Professor of Clinical Surgery, Harper Hospital, Detroit, on the subject "What Should the General Public Know About Cancer?"

* * *

Medical service in California is legally a non-profit service, exempt from all taxes and not under the jurisdiction of the insurance commissioner. Since its inception in 1939, California Physicians' Service, created by the California Medical Association, has been under the jurisdiction of the attorney general of California. Through the appellate court and the superior court of California, the insurance commissioner has attempted to seize control of CPS, and in the latter part of 1945, the commissioner appealed to the supreme court of California for a final decision in the matter. The California supreme court recently upheld the decisions of the two lower courts that CPS is a non-profit service corporation and exempt from all taxes and not under the insurance commissioner's jurisdiction. This definitely defines the legal position of a medical service corporation not organized under a special enabling act (as in Michigan).

* * *

National Conference of County Medical Society Officers will be held in Atlantic City, N. J., Sunday, June 8, 1947. The American Medical Association, upon resolution of its House of Delegates, has established a National Conference of County Medical Society Officers. The first meeting will be held in Atlantic City on the Sunday preceding the Centennial of the AMA, June 8, 1947.

The purpose of this meeting is to "make the AMA a working partner of every American physician." Ideas on socio-economic problems as they affect the general practitioner will be discussed. All present will be requested to exchange thoughts on how the various AMA departments can be most helpful to the American doctor.

All MSMS members are cordially invited to attend the National Conference of County Medical Society Officers.

* * *

Associate Membership for Doctors of Medicine Whose Formal Training Was Interrupted by Military Service.—The Council of the Michigan State Medical Society, on February 1, 1947, adopted the report of its special committee appointed to study the problem of associate membership in the county and state medical societies for young physicians whose period of training was interrupted by military service.

The report of the committee, as approved by The Council of the Michigan State Medical Society, is as follows:

"Article III, Section 4—(2). Any physician heretofore eligible for Associate Membership under Article III, Section 4—(2) of the MSMS Constitution, whose training was interrupted by active military service may, after five years from the date of receiving his first medical degree (M.D. or M.B.), be certified by a county society to the MSMS as an active member. If so certified such physi-

(Continued on Page 364)

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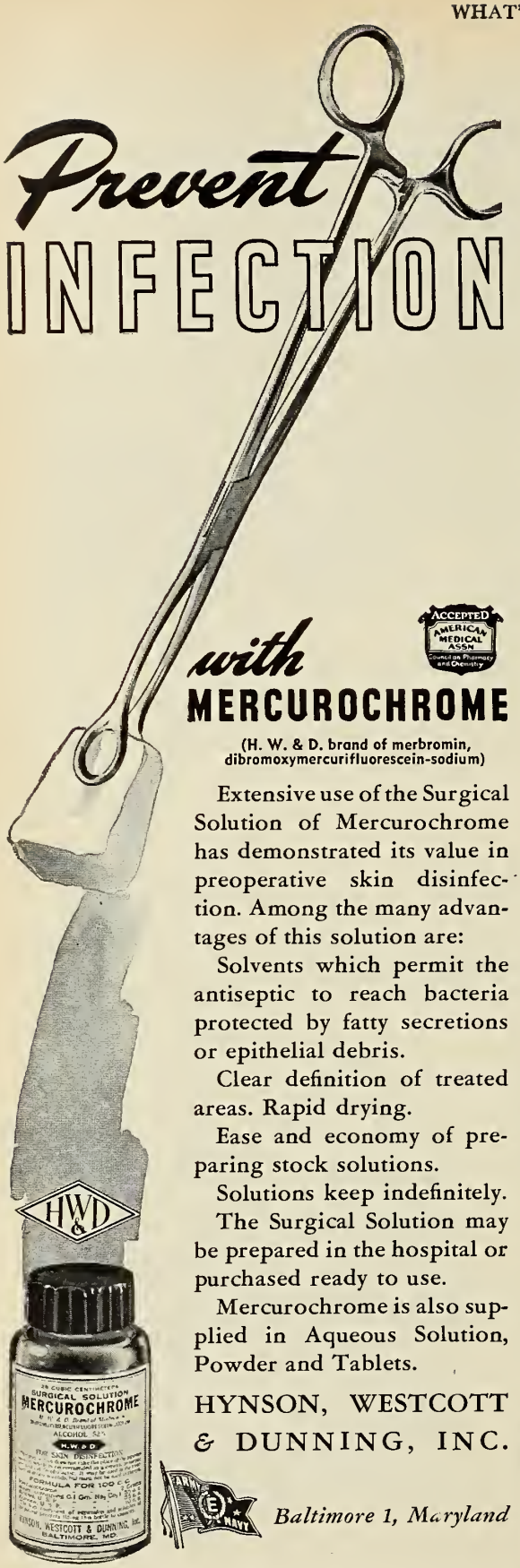

(Continued from Page 362)

cian will be accorded remission of dues for that period of time necessary for and continuously spent in completing his intern, resident, or teaching fellow training, provided, however, that such remission period shall not exceed the actual time spent on active military duty."

* * *

National PR Roundtable.—On February 8, an informal meeting of all public relations counsels of state and county medical societies was arranged in Chicago by the MSMS Public Relations Counsel upon instruction of the MSMS Council in connection with the National Conference on Medical Service—Rural Health. An attendance of eighteen was anticipated; thirty-four attended. A five-hour roundtable discussion disclosed various ideas on promoting better public relations for the medical profession—and a need for further meetings of this same type. In addition to contributions of the State PR Counsel and Executive Secretary, new thoughts were added to programs of modern medical public relations by John F. Hunt of Foote, Cone & Belding, Raymond C. Rich of Raymond Rich and Associates, Tom Hendricks of the AMA Council on Medical Service, Charles Swart, AMA Public Relations Counsel, and others.

* * *

Members of the Michigan State Medical Society and their office employes who are not now Blue Cross members will have an opportunity to enroll in the Michigan Medical Service and Michigan Hospital plans during the month of April, it has been announced by William A. Hyland, M.D., President of the M.S.M.S. Medical Society members and their office employes who are already Blue Cross subscribers and who wish to make changes in their hospital-surgical protection may do so during this enrollment period. New enrollments and changes in present service will be accepted until April 21. The effective date of Blue Cross certificates issued as a result of this enrollment will be May 1, 1947.

Every member of the Michigan State Medical Society will be mailed a Blue Cross application card and explanatory literature for himself and for his office employes. If this material is not received, or if additional application cards are needed, they may be obtained from any Blue Cross district office or from the MSMS Executive Office, 2020 Olds Tower, Lansing 8, Mich.

* * *

Taft Health Bill (*S. 545*). Senators Taft, Ball, Smith and Donnell introduced the 1947 Taft Health Bill on February 10. It was referred to the Committee on Labor and Public Welfare (Senator Taft, Chairman). The revised bill is much improved over the 1946 variety, thanks to the helpful suggestions made during the past year by members of the health, medical, hospital and dental professions.

Senator Donnell (Missouri) proposed the addition of Section 307 to the health bill which is a powerful hedge against deficit financing.

S.545 would create an independent health agency responsible to the President and headed by an outstanding

(Continued on Page 366)

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(Continued from Page 364)

doctor of medicine. It would separate from the control of the Federal Security Agency the health and medical functions of the nation. It would create a strong National Health Agency, which might lead eventually toward cabinet status of health (not mixed with and subservient to social welfare and education).

Copies of S.545 are available by writing Joseph S. Lawrence, M.D., Suite 301, 1302 18th St., N.W., Washington 6, D. C.

* * *

Top Awards Granted by The Council.—The Committee on Awards recommended to the MSMS Council the names of three persons and one organization for recognition as having performed outstanding service in the cause of health. All were approved at the annual session of The Council in Detroit on February 1. They are:

1. Charles F. Kettering, Director of Research, General Motors, Detroit—Grade III Award
2. Michigan Society for Crippled Children and Disabled Adults—Grade III Award
3. Emmet Richards, Chairman of the Michigan Crippled Children Commission and President of the Michigan Society for Crippled Children and Disabled Adults—Grade II Award
4. Percy Angove, Director, Michigan Society for Crippled Children and Disabled Adults—Grade II Award.

County Societies are invited to submit names of local lay persons or organizations who merit recognition for services in the cause of health to L. Fernald Foster, M.D., Chairman of the Committee on Awards. A blank may be obtained from the Executive Office, 2020 Olds Tower, Lansing 8, Michigan.

* * *

The Northern Tri-State Medical Association (Michigan-Indiana-Ohio) will hold its 74th annual meeting at the Rackham Memorial Educational Bldg., Detroit, on Tuesday, April 8, 1947, according to Secretary John L. Stifel, M.D., of Toledo. Speakers include William M. Tuttle, M.D., Detroit, "Recent Advances in Thoracic Surgery"; J. W. Conn, M.D., Ann Arbor, "Recent Advances in the Treatment of Diabetes"; Sprague H. Gardiner, M.D., Indianapolis, "Recent Developments in the Management of the Menopause"; William Magner, M.D., Toronto, "Enigmatic Anaemias"; Frederick A. Coller, M.D., Ann Arbor, "Surgical Aspects of the Abdominal Wall"; Laurence H. Snyder, M.D., Columbus, "Medical Genetics and Public Health"; and Edward D. Spalding, M.D., Detroit, "Recent Advances in Cardiology."

George F. Lull, M.D., Chicago, Secretary-General Manager of the American Medical Association, will be the luncheon speaker.

All members of the Michigan State Medical Society have been cordially invited by President Douglas Donald, M.D., Detroit, to attend.

Wm. H. Gordon, M.D., and E. D. Spalding, M.D., Detroit, are members of the six-man Council of the Northern Tri-State Medical Association.

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Pediatrics	May 5- 7, 1947
Heart, Diseases of the	May 12-16, 1947
Gastrointestinal Tract, Disease of the	May 19-23, 1947
Therapeutics, Recent Advances in	May 26-29, 1947
Blood, Diseases of the	June 2- 6, 1947
Allergy	June 16-20, 1947
Metabolism and Endocrinology	June 23-28, 1947
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(Continued from Page 331)

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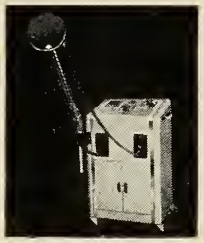

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Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

THE ESSENTIALS OF OBSTETRICS AND GYNECOLOGY. By William Albert Scott, B.A., M.B., F.R.C.S. (Can.), F.R.C.O.G. (Eng.), Professor of Obstetrics and Gynecology, University of Toronto, and H. Brookfield Van Wyck, B.A., M.B., F.R.C.S. (Can.), F.R.C.O.G. (Eng.), Assistant Professor of Obstetrics and Gynecology, University of Toronto. Octavo, 390 pages, with 126 illustrations on 91 figures, 13 in colors. Philadelphia: Lea & Febiger, 1946. Price, $5.50.

The specialties of Obstetrics and Gynecology have become separated, but in this text the authors believe they should be sufficiently combined to allow for proper instruction and training. They must necessarily be kindred in practice. The subjects have been well covered in few words, well marshalled for instruction purposes for student and busy practitioner who cannot or has not the time to enter into controversial or unnecessary research. The book is authoritative, and up to date, but does not get the puerperal woman up on her feet, and about the house the second or third day. The authors are conservative in all their recommendations, and thus give a reliable text to follow. Their advice on therapeutic abortion and contraception is guarded, calling attention to religious and moral beliefs that must be respected.

COURAGE AND DEVOTION BEYOND THE CALL OF DUTY, Being a record of official citations to medical officers in the United States Armed Forces during World War II. Second Preliminary Edition, July 1946. Evansville, Indiana: Mead Johnson Company.

This is a cardboard covered edition devoting a page to each citation. There are over a thousand pages, about seventy being devoted to groups, and the rest to individual doctors. This amazing mass of laudatory articles testifies to the devotion and sacrifice made by these doctors in serving their country.

THE COMPLEAT PEDIATRICIAN, Practical Diagnostic Therapeutics and Preventive Pediatrics. Fifth Edition, for the use of Medical Students, Interns, General Practitioners, and Pediatricians. By Wilburt C. Davison, M.A., D.Sc., M.D., Professor of Pediatrics, Duke University School of Medicine, and Pediatrician, Duke Hospital. Formerly Acting Head of Department of Pediatrics, The Johns Hopkins University School of Medicine, Acting Pediatrician in Charge, The Johns Hopkins Hospital, and member American Board of Pediatrics. Fellow American Academy of Pediatrics and American College of Physicians, Member, American Pediatric Society, and Division of Medical Sciences, National Research Council, Durham, N. C. Printed by Seeman Printery for Duke University Press 1946. Prices, $3.75 and $4.00.

In this fifth edition of what has become a Pediatric Bible, the author has added the information gleaned from over 1,700 pediatric articles written during the past three years. The book lists up-to-the-minute methods of treatment, including the new antibiotics. It describes new, but established, laboratory procedures, complete diagnostic tables, food and vitamin charts, and many recently described diseases and syndromes.

The reader who wants a handy reference book in this field will find this volume invaluable. It is concise, factual, and authoritative.

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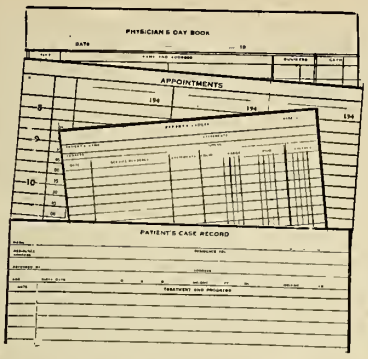

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As the author states in the preface, "In contrast to many pediatric books which too often resemble the old-fashioned hoopskirt in covering the subject without touching it, this book is like a G-string in touching the subject without any pretense of covering it."

R.L.S.

ANIMAL FARM. By George Orwell. 118 pages. Harcourt, Brace and Company, 383 Madison Avenue, New York 17, N. Y.

This amusing but important contribution to thoughtful literature tells, in poignant style, of a successful revolution staged by the animals on Mr. Jones' farm. Enthusiastically, they set up a great commandment "All Animals Are Equal," but unfortunately leadership devolves almost automatically on the pigs, who are on a higher intellectual level than the rest.

The revolution begins to go wrong—yet at every step excellent excuses are always forthcoming for each perversion of the original doctrine.

As a story, "Animal Farm" is excellent company for two hours—but it also takes on meanings from what we have all noticed in the affairs of the world recently. The heart and the head join in enjoyment of "Animal Farm."

CLINICAL LABORATORY DIAGNOSIS. By Samuel A. Levinson, M.D., Professor of Pathology and Assistant Professor of Medicine, University of Illinois College of Medicine, Chicago, and Robert P. MacFate, Ch.E., Ph.D., Assistant Professor of Pathology, University of Illinois College of Medicine, Chicago. Director and Assistant Director, respectively, of the Research and Educational Hospitals, Chicago, Illinois. Third Edition, Philadelphia: Lea & Febiger, 1946. Price, $10.00.

This is the third edition of a book that has established a reputation for worth and all-inclusiveness in the preceding editions. It is filled with many clinical aphorisms, which may be a bit dogmatic, or a trifle clouded, as the page-long discourse on the clinical import of blood iodine, but their correlation with the laboratory

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methods and findings is excellent. In an effort to cover the field many procedures are abbreviated to the point where the explanation is not adequate, for this reason one wonders if the sections on toxicology and tissue technique should not be deleted and if a new section dealing with tropical medicine should have been added to the present edition. It is particularly recommended to those physicians who wish to limit their library to one book on the subject.

A.A.H.

PHARMACOLOGY AND THERAPEUTICS. Originally written by Arthur R. Cushney, M.A., M.D., LL.D., F.R.S., Late Professor of Materia Medica, and Pharmacology in the University of Edinbourgh. Thirteenth Edition, thoroughly revised by Arthur Grollmen, A.B., Ph.D., M.D., F.A.C.P., Professor of Medicine and Chairman of the Department of Experimental Medicine, and Professor of Pharmacology and Chairman of the Department of Pharmacology and Physiology, The Southwestern Medical College, et cetera, Dallas, Texas; and Donald Slaughter, B.S., M.D., Dean of the Medical School, University of South Dakota, formerly Professor of Pharmacology and Chairman of the Departments of Physiology and Pharmacology, The Southwestern Medical College, Dallas, Texas. Illustrated with 74 Engravings. Philadelphia: Lea & Febiger, 1947. Price, $8.50.

Since 1899, Cushney's Pharmacology and Therapeutics has been the standard text which we have all studied and referred to, over these many editions. The editors of the last four editions, Professor C. W. Edmunds of the University of Michigan, and Professor J. A. Gunn, of the University of Oxford, have both died, but the science of pharmacology and therapeutics has marched on in the form of chemotherapy, endocrinology, the vitamins, antibiotics. The editors of this present edition have retained the features of the Cushney which made it such a great teaching text, but have added the newer features enumerated. The text is just as clear, and is prepared for the student and practitioner of medicine, rather than as a complete compendium of pharmacological knowledge. Much of the old book has been eliminated in favor of more modern methods and needs. Emphasis on the scientific basis of therapeutics has been rightfully retained.

The newer sulfonamides, penicillin, streptomycin, and other biotics have been included in this textbook—a first appearance. The book is over 860 pages of meat, and is needed in the resources of the modern practitioner.

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ALLERGY IN THEORY AND PRACTICE. By Robert A. Cooke, M.D., Sc.D., F.A.C.P., Attending Physician and Director of the Department of Allergy, the Roosevelt Hospital, New York City. 572 pages, with 43 illustrations. Philadelphia and London: W. B. Saunders Company, 1947. Price, $8.00.

Dr. Clarke has produced an excellent book on allergy, with exact details and procedures, and with discussions of the action and treatments of numerous allergic conditions. The basic theory and practice of testing and diagnosis is given in detail. Then the book discusses the various allergic diseases, asthma and all its ramifications, whether toxic or not. The discussion of allergic dermatoses is full and outlines of diagnosis and treatment given. There is a section on migraine, Ménière's disease, cardiovascular and digestive system allergies, allergy of the eye, inhalants, skin testing, et cetera. This book is well written and the author gives his opinions, and those of his staff. At the end of each chapter is a list of references for further intensive study.

AN INTEGRATED PRACTICE OF MEDICINE—A Complete General Practice of Medicine from Differential Diagnosis by Presenting Symptoms to Specific Management of the Patient. By Harold Thomas Hyman, M.D., Volumes I, II, III, and IV, and Index. 1184 illustrations, 305 in color. 319 Differential Diagnostic Tables. Philadelphia and London: W. B. Saunders Company, 1947. Price, $50.00 per set.

This set of books consists of three volumes and an index number, and represents a complete General Practice of Medicine by symptoms to specific management of the patient. The tables of differential diagnosis are extensive and should, with proper history and careful physical examination, point the way to the correct diagnosis. The author has approached the complex problem of therapy, as we know it today, in a very logical and simplified manner so that the patient should receive the best of latest scientific therapy. We believe this set of books will be a valuable addition to the general practioner's library, and equally valuable to the specialist in seeking knowledge outside his special field of practice.

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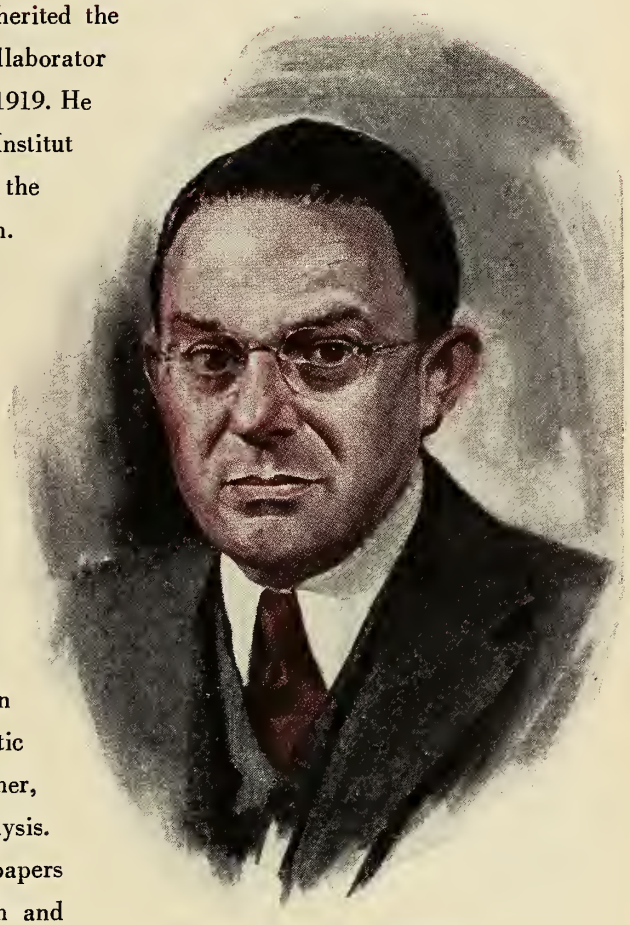
Max Bergmann may be said to have inherited the mantle of Emil Fischer, whose principal collaborator he was at the time of the latter's death in 1919. He became Director of the Kaiser Wilhelm Institut für Lederforschung and, later, Member of the Rockefeller Institute for Medical Research. In 1925 he identified the dehydropeptides, substances of physiological interest which serve as substrates for a highly specific enzyme system. His "carbobenzoxy method", announced in 1932, provided a new, elegant technique for the synthesis of peptides. This led to the proposal of a system for step-by-step degradation of polypeptides, permitting successive removal and identification of individual amino acids. His investigations on protein structure and the specificity of proteolytic enzymes fostered the development of finer, more precise methods of amino acid analysis. Bergmann's more than 300 published papers contributed brilliantly to modern protein and carbohydrate chemistry, which are part of the foundation on which medical science rests.



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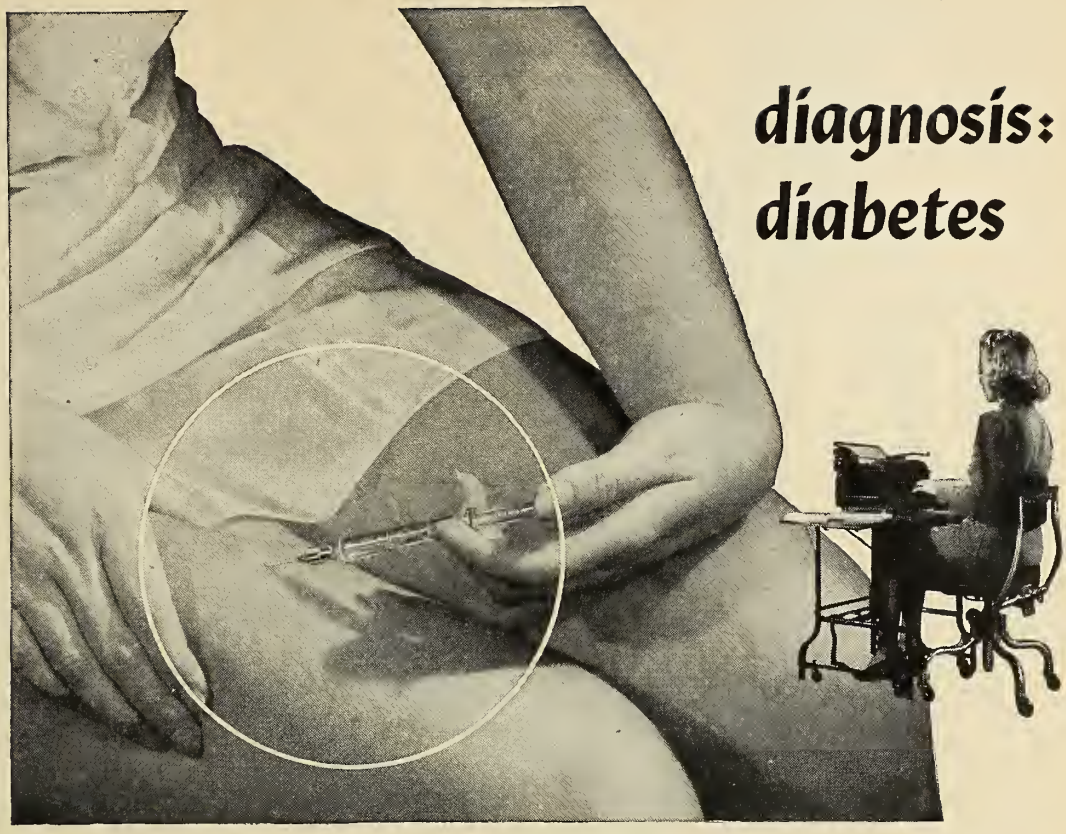

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Hoekstra, Jr. and Steggerda, F. R. Fed. Proc. 5:48-9, Feb., 1946.
Koepf, G. C., Arbesman, C. E. and Lenzner, A. Fed. Proc. 5:56-7, Feb., 1946.
Craver, B. N., Seip, P., Cameron, A. and Yonkman, F. F. Fed. Proc. 5:172, Feb., 1946.
Mathieson, D., Hays, H. W., Chess, D., Cameron, A. and Yonkman, F. F. Fed. Proc. 5:192-3, Feb., 1946.
Sherrod, T. R., Schloemer, H. F. and Loew, E. R. Fed. Proc. 5:202, Feb., 1946.
Yonkman, F. F., Chess, D., Hays, H. W., Rennick, B. and Mayer, R. L. Fed. Proc. 5:216, Feb., 1946.
Epstein, S. Wisc. Med. J. 45:489-96, May, 1946.
Mayer, R. L. J. Allergy 17:153-65, May, 1946.
Sangster, W., Grossman, M. I. and Ivy, A. C. Gastro. 6:436-8, May, 1946.
Friedlaender, S., Feinberg, S. M. and Feinberg, A. R. Proc. Soc. Exp. Biol. & Med. 62:65-7, May, 1946.
Friedlaender, S. and Feinberg, S. N. J. Allergy 17:129-41, May, 1946.
Baer, R. L. and Sulzberger, M. B. J. Inves. Derm. 7:147-8, June, 1946.
Horton, B. T. and Macy, D., Jr. Med. Clin. N. A. 811-31, July, 1946.
Mayer, R. L., Hays, H. W., Brousseau, D., Mathieson, D., Rennick, B. and Yonkman, F. F. J. Lab. & Clin. Med. 31:749-51, July, 1946.
Friedlaender, S. Am. J. Med. 1:174-9, Aug., 1946.
Yonkman, F. F., Chess, D., Mathieson, D. and Hansen, N. J. Pharm. & Exp. Thera. 87:256-64, July, 1946.
Arbesman, C. E., Koepf, G. F. and Miller, G. E. J. Allergy 17:203-9, July, 1946.
Feinberg, S. M. J. Allergy 17:217-30, July, 1946.
Unger, L. Ann. Allergy 4:299-334, July-Aug., 1946.
Baer, R. L. and Sulzberger, M. B. J. Inves. Derm. 7:201-6, Aug., 1946.
Lesser, M. A. Drug & Cosmetic Ind. 59:334-6 and 422-6, Sept., 1946.
Koepf, G. F., Arbesman, C. E. and Munafo, C. J. Allergy 17:271-4, Sept., 1946.
Arbesman, C. E., Koepf, G. F. and Lenzner, A. R. J. Allergy 17:275-83, Sept., 1946.
Chobot, R. J. Allergy 17:325-6, Sept., 1946.
Epstein, S. Geriatrics 1:369-83, Sept.-Oct., 1946.
Curry, J. J. Med. Clin. N. A., 1138-48, Sept., 1946.
Mayer, R. L., Eisman, P. C. and Aronson, K. J. Bact. 52:257-8, Aug., 1946.
Editorial: Ann. Allergy 4:399-400, Nov., 1946.
Queries and Minor Notes: J.A.M.A. 132-183, Sept. 21, 1946.
Feinberg, S. M. J.A.M.A. 132:702-13, Nov. 23, 1946.
Mayer, R. L. and Brousseau, D. Proc. Soc. Exp. Biol. & Med. 63:187-91, Oct., 1946.
Barach, A. L. J. Allergy 17:352-7, Nov., 1946.
Editorial: J. Allergy 17:399-400, Nov., 1946.
Morginson, W. J. J.A.M.A. 132:915-9, Dec. 14, 1946.
Goodhill, V. Laryngoscope 56:687-92, Nov., 1946.
Allen, F. N. Lahey Clin. Bull. 5:52-7, Oct., 1946.
Huttrer, C. P., Djerassi, C., Beears, W. L., Mayer, R. L. and Scholz, C. R.: J.A.C.S. 68:1999-2002, Oct., 1946.
Friedlaender, A. S. and Friedlaender, S. North End Clin. Quart. 7:14-18, Oct., 1946.
Selle, W. A. Texas Rep. Biol. & Med. 4:435-45, Winter, 1946.
Friedlaender, A. S. and Friedlaender, S. J. Lab. & Clin. Med. 31:1350, Dec., 1946.
Tatum, A. L. Wisc. Med. J. 45:1147, Dec., 1946.
Glaser, J. Am. Pract. 1:185-90, Dec., 1946.
Pyribenzamine—(PBZ). Heb. Med. J. 2:151-150, 1946.

COUNCIL ACCEPTANCE

Pyribenzamine now has been formally accepted by the A.M.A. Council on Pharmacy and Chemistry. A report to the Council on anti-histaminic agents was written by S. M. Feinberg, M.D., in the November 23, 1946 issue of the J.A.M.A. Pyribenzamine was found to be highly effective, and produces relatively few side effects.

FOR YOUR CONVENIENCE—in obtaining sample and literature, we suggest you fill out and mail us the coupon.

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SEND PYRIBENZAMINE SAMPLE AND REPRINT OF COUNCIL REPORT ON ANTI-HISTAMINIC AGENTS.

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CITY_____ STATE_____

You and Your Business

TAFT-BALL-SMITH-DONNELL HEALTH BILL OF 1947

The 1947 revised "Taft Health Bill" was introduced into Congress on February 10. Many favorable improvements are found in S.545 which embodies suggestions made during the past year by members of the medical, hospital and dental professions. The principal changes are as follows:

1. The appointment of a Director for the Office of Medical and Hospital Care Service, who must be an M.D.
2. An appropriation of 3 million dollars for grants in aid to states for surveys of medical and hospital care needs.
3. An appropriation of one million dollars as grants in aid to the States for dental care survey. The survey appropriations are based on a matching formula for reimbursement to States similar to the plan in the Hospital Construction Act of 1946.
4. The elimination of the possibility of the U. S. Public Health Service taking over the program. Public Health Service is established as one of the offices of the National Health Agency.
5. An appropriation of 10 million dollars to Public Health Service for cancer research, control and preventive study, for grants in aid to the States.
6. Funds for the program shall be made available and deposited with the Secretary of the Treasury at the beginning of each fiscal year. This will eliminate the practice of spending money not yet available from taxing sources.
7. The creation of an independent agency of government for health with the director responsible only to the President and Congress.

Nearly $7,000,000 for Michigan

A payroll deduction from federal employes for medical-hospital care services would be allowed under the Taft Health Bill of 1947—a provision of extreme interest to voluntary health plan such as Michigan Medical-Michigan Hospital Services.

The proposed annual allocation to Michigan in accordance with the matching provisions of S.545 is $6,977,000 on the basis of the total yearly allocation of $200,000,000.

Consolidation of Health Agencies

The following agencies are transferred to or incorporated in the National Health Agency:

Public Health Service
St. Elizabeths Hospital
Food and Drug Administration
Children's Bureau concerned with the administration of Title V Part 1-2 of the Social Security Act
Division of Health Studies in the Bureau of Research and Statistics of the Social Security Administration
Office of Medical and Hospital Care Service
Office of Dental Care Service
Office of Maternal and Child Health
Office of Health Statistics

SEND YOUR STATEMENT—IN DUPLICATE

The statutory provisions of the Crippled Children's Act and the Afflicted Children's Act require that payment shall *not* be made by the Michigan Crippled Children Commission for services if billing is delayed over 60 days from date of discharge of the patient. Inasmuch as the physician's services are billed through the hospital, it must be the responsibility of the physician to see that the hospital properly submits his billing to the Commission.

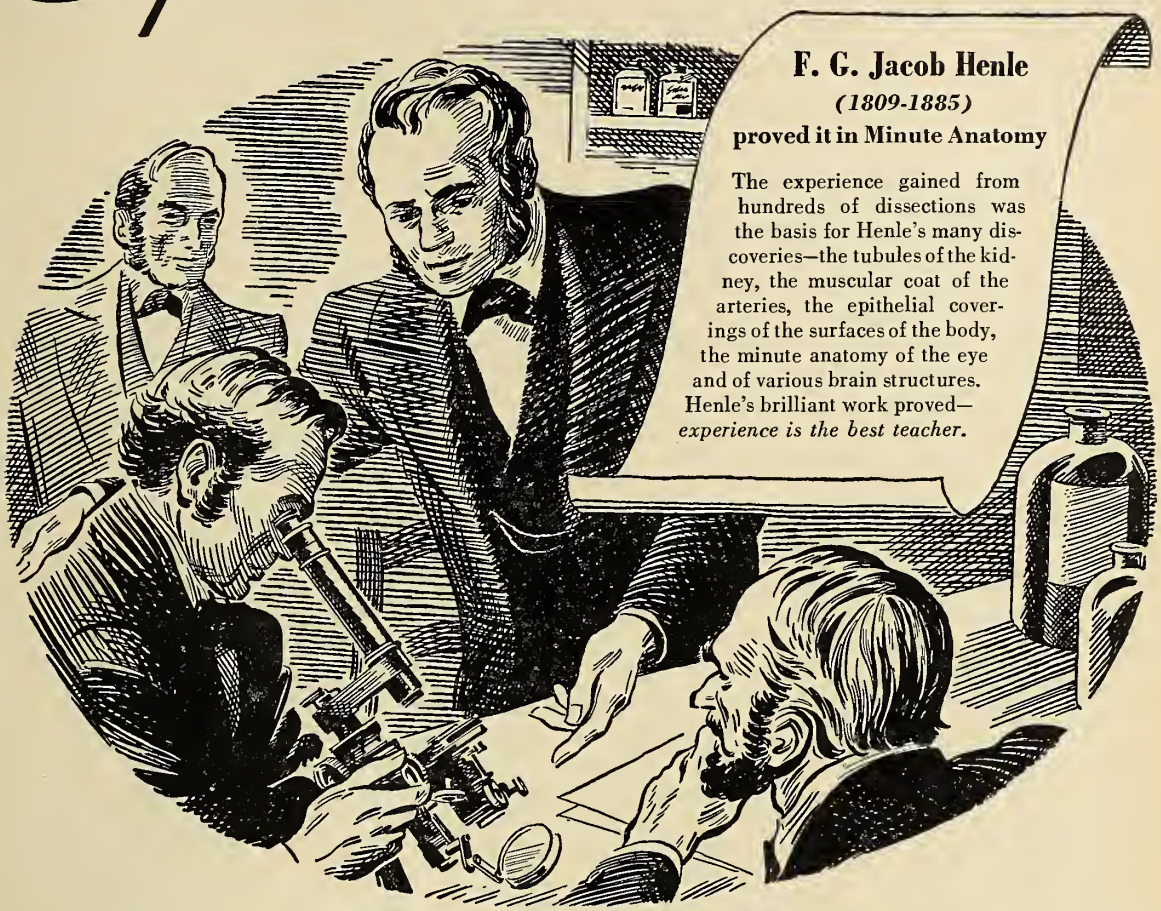
The Michigan Crippled Children Commission recommends that the physician prepare a statement of his services in duplicate at the end of each month, sending one copy to the hospital and one copy to the Commission. This suggestion is made in order to protect the physician in the event that the hospital should fail to bill for his services within the time specified according to Statutory provisions, or should bill for a lesser amount than that set forth in the MCCC Schedules of fees for professional services.

MICHIGAN'S RHEUMATIC FEVER DIAGNOSTIC CENTERS

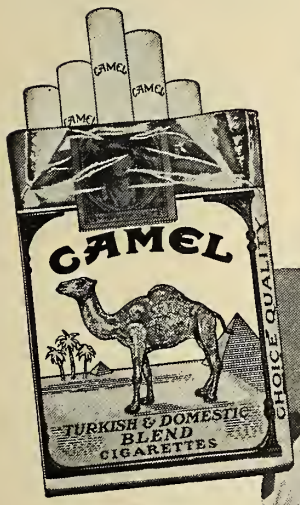
Rheumatic Fever Diagnostic Centers have been established by the Michigan State Medical Society in 10 areas covering the entire state of Michigan. This unique program of aid to the doctor of medicine in diagnosing the Number One killer of

(Continued on Page 392)

Experience is the Best Teacher



Yes, and experience is the best teacher in smoking too!



THE wartime cigarette shortage was a real experience to smokers. Whether they intended to or not, people found themselves smoking many different brands, learning by actual experience the differences in cigarette quality.

The result of all these comparisons was the biggest demand for Camels in history. And today more people are smoking Camels than ever before. But, no matter how great the demand:

We don't tamper with Camel quality. Only choice tobaccos, properly aged, and blended in the time-honored Camel way, are used in Camels.

According to a recent Nationwide survey:

MORE DOCTORS SMOKE CAMELS

than any other cigarette

R. J. Reynolds Tobacco Co.
Winston-Salem, N. C.

MICHIGAN'S RHEUMATIC FEVER DIAGNOSTIC CENTERS

(Continued from Page 390)

children is sponsored by the Michigan State Medical Society in co-operation with the Michigan Society for Crippled Children and Disabled Adults and the Michigan Crippled Children Commission.

Active centers are in operation in the following communities:

Ann Arbor—H. H. Riecker, M.D., Chairman
Bay City—L. Fernald Foster, M.D., Chairman
Grand Rapids—Leon DeVel, M.D., Chairman
Kalamazoo—H. S. Heersma, M.D., Chairman
Lansing—Horace French, M.D., Chairman
Marquette—M. Cooperstock, M.D., Chairman
Traverse City—Mark Osterlin, M.D., Chairman.

Centers now preparing for early operation include:

Flint—M. S. Chamber, M.D., Chairman
Jackson—Frank Van Schoick, M.D., Chairman
Detroit—Norman E. Clarke, M.D., Chairman

SOME BENEFITS OF MEMBERSHIP IN THE MICHIGAN STATE MEDICAL SOCIETY

....Professional

.....Educational

.....Economic

.....Sociologic

1. A position of social responsibility in the community—the trust and opportunity of the medical profession to assume leadership in all medical matters.
2. Your common interests safeguarded through the vigilant work of democratically selected officers and committeemen who are men of your own kind (a) who know your problems and those of your patients; (b) who serve generously without compensation; (c) who need and ask for your co-operation and advice.
3. Maintenance and constant improvement of standards of medical practice for the protection of patients.
4. Protection against state and national legislation inimical to public interests and advancement of medical science; constructive efforts to initiate beneficial health measures; important contacts to effect the proper administration of existing laws.
5. Information and technical advice in medical legal matters.
6. Defense of your profession and your source of livelihood against encroachments from without.
7. Authentic information to an inquiring public regarding good medical service and the standing of practitioners.
8. A monthly Journal of high quality with the latest scientific literature, and general information important to you.
9. Personal service of your Executive Office in Lansing in matters associated with your practice of medicine.
10. Your medical societies act as sales ambassador of the medical profession in your community and the State.

The returns you receive from membership in the Michigan State Medical Society are almost unlimited.

Your destiny is intimately related to the success of your county, state and national medical organizations.

YOUR PHOTOGRAPH, DOCTOR!

Joseph Merante, Jr., portrait photographer, 475 Fifth Avenue, New York, will visit Michigan beginning May 1 to take photographs of all members of the Michigan State Medical Society, for the purpose of building up the portrait album in the Executive Office of the Michigan State Medical Society. Without any obligation to the individual member or to the Michigan State Medical Society, Mr. Merante has agreed to furnish a glossy print of the portrait of every member of the State Society who sits for a photograph. The co-operation of the membership is invited. It is hoped that through this arrangement, the archives of the Michigan State Medical Society will include a photograph of every member.

WAGNER-MURRAY-DINGELL SOCIALIZED MEDICINE

Senator Wagner announced in the *Detroit Free Press,* Sunday, February 16, 1947, that he was about ready to introduce in Congress his newest Wagner-Murray-Dingell Bill. He was very unspecific as to what the bill would contain, but has had much experience in rewriting the bill, and should come up with a brand new version, and one which would be much more sugar-coated than any former attempt.

We are waiting for this newest version of what its author without doubt will claim is NOT SOCIALIZED MEDICINE. Knowing the past, we know what to expect.

In Hawaii on January 22, 1947, a series of articles in the *Honolulu Advertiser* reported a plan for compulsory hospital insurance as the result of work of the Hospital Service Study Commission. The scheme will be available to all persons of income up to $5,000, about 80

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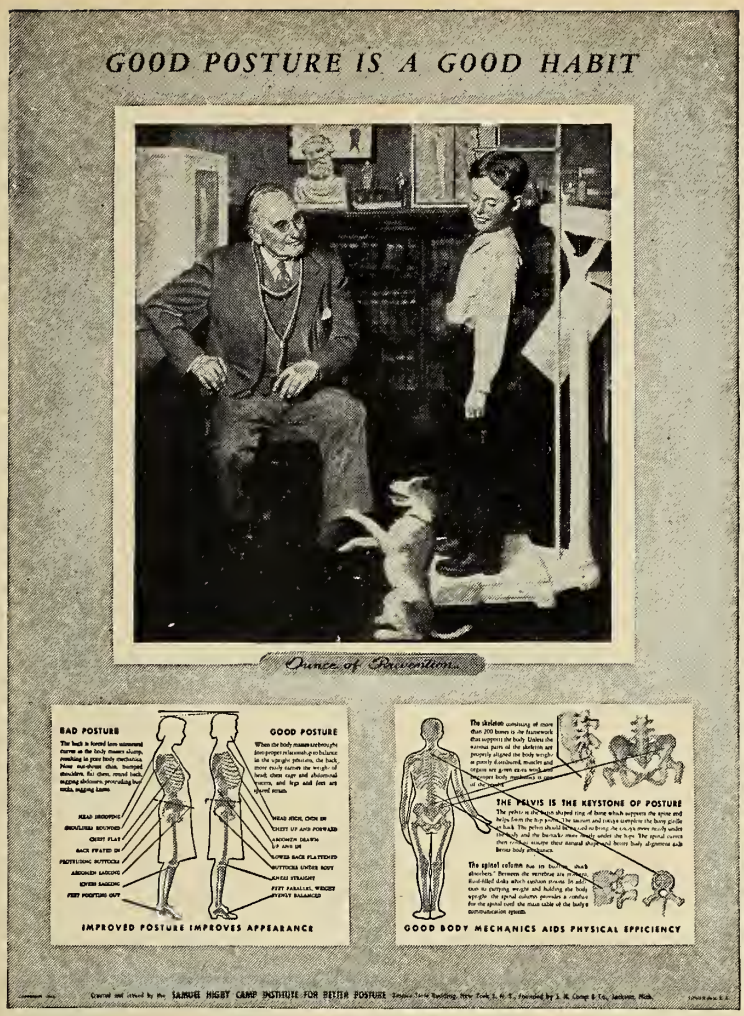

FREE: HUMAN INTEREST GOOD POSTURE CHART in full color 18"x24" designed for physicians' offices, clinics and health centers. One in a standard series widely distributed in schools, colleges, industrial plants, "Y's" and similar outlets. Write for your office copy of this educational chart on your professional letterhead to SAMUEL HIGBY CAMP INSTITUTE FOR BETTER POSTURE, EMPIRE STATE BLDG., NEW YORK 1, N. Y.

9th ANNUAL

CAMP

NATIONAL POSTURE WEEK

MAY 5—10

In its ninth year, National Posture Week continues its sound ethical program of focusing the attention of the country on the significance of Good Posture as an important element in good health and physical fitness.

Distribution of authentic literature through schools, colleges, medical and government bodies; and industrial, professional and civic public health groups is an important part of the program. Physicians, educators and lay groups in the field of public health have shown in practical cooperation and voluminous correspondence that they approve the methods of National Posture Week and its year-round program.

It is our hope that our current campaign will again merit the approval and cooperation of the medical profession.

S. H. CAMP & COMPANY, Jackson, Michigan
World's Largest Manufacturers of Scientific Supports
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FREE: These two heavily illustrated 16 page booklets on posture prepared especially for distribution by physicians to their patients. Their titles are: "The Human Back . . . its relationship to Posture and Health" and "Blue Prints for Body Balance." Ask for the quantity you need on your professional letterhead. THE SAMUEL HIGBY CAMP INSTITUTE FOR BETTER POSTURE, Empire State Bldg., New York 1, N. Y. Founded by S. H. Camp & Company, Jackson, Mich.

The Most Important Legislation

Social Security legislation is the most important of all legislation. In the past, employers have not had to be too concerned about federal schemes for control of unemployment compensation as the various state unemployment compensation agencies and their administrators have been very effective in preserving "states rights." However, no such forces are at work in the field of social security generally. If we are to prevent the establishment of a unified national social security system promising protection for all of the misfortunes of the American population from the cradle to the grave, the public must be aroused to the dangers in such a system.

Nothing really new looms ahead for 1947; the proposals will be largely a repetition of efforts put forth last year and the years before to pass legislation providing cradle-to-grave social security program.

These proposals will undoubtedly include:

1. Extension of Social Security coverage to everyone, including federal, state, county, city employes; employes of religious, charitable and educational organizations, self-employed, et cetera.
2. Liberalization of benefits of Social Security program extending minimum and maximum payments, et cetera.
3. Attempt to eliminate experience rating in unemployment compensation tax and make flat rate of at least 3 per cent. Present over-all rate in about .8 of 1 per cent, based on experience rating earned by employer.
4. Change basis of granting public assistance to State from matching 50/50 to variable grant system which would be based on income and wealth of respective states—the poorer states receiving more federal aid.
5. Elimination of state unemployment compensation system in favor of a federal system.
6. Tax rate of social security for 1948 will go to 2.5 per cent if it is not set lower by Congress in 1947. Effort should be expended to freeze this tax to 1 per cent permanently or put program on pay-as-you-go plan, paying in 1948 only amount expended from reserves in 1947, and so on. Reserve is now 7.5 billion—fourteen times more than required. Income at 1 per cent is 1.5 billion per year—disbursements are about 200 million per year. Absolutely no need exists for an increase in rate.

A Choice Must Be Made

We must choose between (1) a powerful socialized paternalistic central or Federal government compelling the thrifty and ambitious working half of our population to support the other half in idleness at a standard of living they might have if they too were thrifty, ambitious and working; (2) or preserving the traditional American way of opportunity for employment and success for those who are willing to work. We must retain the capitalist system, the profit motive, the right of a man or woman to be rewarded for energy, initiative, imagination, daring, the character to save, and the courage to invest.

STOP—LOOK—LISTEN

STOP telling the patient there is nothing wrong with him but nerves—Don't say: Go home and forget it.
LOOK for the facts as the patient sees them.
LISTEN attentively to patient's story.

* * *

Fear is an emotion arising from lack of security. It may or may not manifest itself in some disguised way.

* * *

A sense of humor is a good thing, but trying to be a professional funny-man soon makes people tire of you.

* * *

Shock treatments are only part of the treatment of some who are mentally ill. They should be given only to carefully selected cases in association with and followed by appropriate psychotherapy.

* * *

Whether or not you are in doubt about organic disease, do not forget to search the personality of the patient.

* * *

The neurasthenoid person is a moral masochist—train him to think of his successes, not his failures.

* * *

Intelligence and emotions do not parallel each other. You can have an I.Q. of 125 and still be an emotional moron.

* * *

Few people are hurt by overwork. More are injured by what they do and think when they are not working.

MSMS Mental Hygiene Committee.

3 advantages...

1 "Premarin" ...Effective when given by mouth

2 "Premarin" ...Rarely produces unpleasant side reactions

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The average suggested dosage is 1.25 mg. to 3.75 mg. daily. Once symptoms have subsided, dosage may be gradually reduced to a maintenance level of 0.625 mg. daily or less.

"Premarin" is available as follows:

Tablets of 1.25 mg. in bottles of 20, 100 and 1000.
Tablets of 0.625 mg. in bottles of 100 and 1000.
Liquid containing 0.625 mg. per 4 cc. (one teaspoonful) in bottles of 120 cc.

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Athletic Accident Benefit Plan — Michigan High School Athletic Association

By Charles E. Forsythe
State Director of High School Athletics

IN PRESENTING this discussion of the Athletic Accident Benefit Plan of the Michigan High School Athletic Association, I immediately want to make it clear that I am neither an authority on medical treatment of injuries which may be received in athletics, nor an insurance statistician. Rather, my purpose in presenting this subject here at the request of your Executive Committee is to acquaint the members of the medical profession with the Benefit Plan which has been developed in Michigan as an aid to schools in the conduct of their interscholastic, intramural, and physical education programs.

In 1939 our Association contacted the insurance companies doing business in this state which wrote accident and casualty insurance to ascertain whether or not any of them were interested in the type of coverage for some of the more common accidents which occurred in activities of this kind. The answer from all of them was that they had no experience on which to base such a coverage and could offer no aid at that time. Because many school men of the state were interested in some program of this type we canvassed the country to see what plans, if any, were in effect in other states and as a result of the study made, the Benefit Plan now in effect in Michigan was established in September, 1940.

General Types of Benefit Plans

There are essentially three general types of benefit plans which are operating in various sections of the country. Wisconsin was the pioneer in this development and set up the first state association-operated benefit plan in the United States in 1930. It provides for the payment of one fee for a registered student which covers him in all sports and physical education activities in which he engages in the school. All dealings are directly with the school itself, rather than with the student, physician, or dentist involved. The Wisconsin plan has been the basis for a large majority of the twenty-six state high school athletic associations which now operate athletic accident benefit plans.

In New York and California a different scheme has been set up. It provides for an individual sport registration plan, i.e., a student is covered for football for a definite fee and basketball for additional fee, et cetera. In those two states especially, the State Workmen's Compensation schedule of fees has been used as the basis for accident payments. In that connection may I say that the student registration fees in those states are somewhat higher than those in other states which have set up their own schedules.

The third plan in operation in a few states is an arrangement entered into by the high school associations with regular insurance companies which in turn handle the details relative to registration of students and payment of claims. In those cases it is a regular insurance procedure and dealings are directly with the insured. In Iowa a regularly incorporated Iowa High School Insurance Company has been formed which in reality is the State Athletic Association itself.

The Michigan Plan

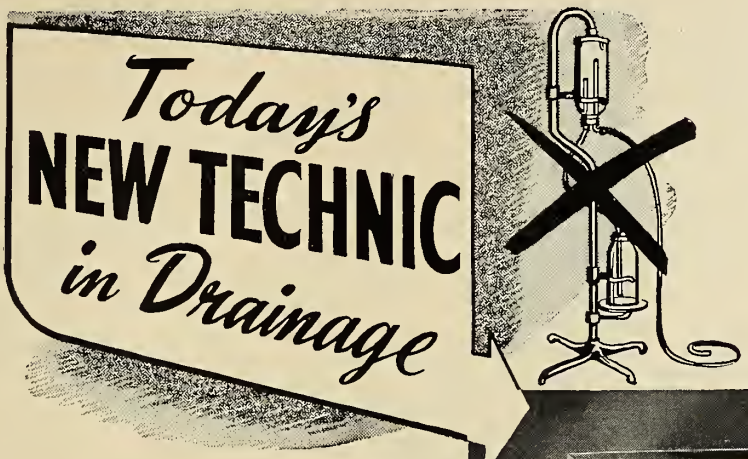
As indicated above the various plans in effect in other states were considered before that in Michigan was established. As also indicated we took the essentials of the Wisconsin plan and set up the organization in Michigan upon the advice and approval of the State Insurance Commission and the Attorney General. We have definitely been designated as "not being in the insurance business." Our State Association announced to schools that, by the payment of a school membership fee varying from $3.00 to $15.00, depending on the size of the school, and for a student registration fee of $1.75 for all sports or $1.00 for all sports except football, it would attempt to meet an established schedule for injuries incurred which virtually was that used in Wisconsin for several years. At the outset, it was pointed out that the Benefit Plan in Michigan simply was an aid to schools in the conduct of their interscholastic, intramural, and physical education program. All dealings were to be directly between the Benefit Plan and the school itself; none was to be carried on between Benefit Plan and the individual student or the attending physician or dentist. No guarantee was or ever has been made that all scheduled benefits could be paid in full but schools were assured that they would receive as much of the scheduled allowances as possible after costs of administering the Plan were deducted. An arrangement also was incorporated in the Michigan Plan to provide that non-scheduled injuries might be reported and would receive consideration for at least partial payment at the close of the school year after the regularly scheduled benefits had been paid in full, provided funds were available. During the six years of operation of the Plan an average of $4,000 per year has been paid to member schools for non-scheduled injuries because, during each year, all regularly scheduled benefits have been paid in full.

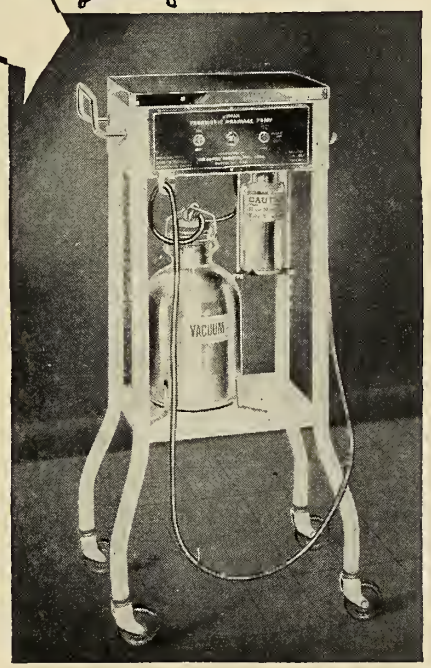
I desire to make it clear that the schedule of benefits as established by the Athletic Accident Benefit Plan is in no way a dictation to the medical or dental profession as to their charges for professional services rendered. Rather it is an indication of the amount we are able to reimburse schools in connection with injuries which may be received by their registered students. The fact

(Continued on Page 398)

Presented at the Annual County Secretaries and Public Relations Conference of the Michigan State Medical Society, Detroit, February 2, 1947.

Mr. Forsythe is secretary-treasurer of the Athletic Accident Benefit Plan.





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60 COLUMBIA ST. WEST FOX THEATRE BUILDING

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(Continued from Page 396)

that last year the Benefit Plan paid back to schools approximately 88 per cent of their total membership and student registration fees indicates that the schedules as established are essentially all that can be allowed in proportion to the amounts now being paid by them for Benefit Plan coverage. In some instances physicians and dentists have felt that it wasn't the prerogative of the Benefit Plan to set the fees they should charge. I want to dispel any idea that the fees we have set up were established with that purpose in mind.

Growth of the Benefit Plan

During the 1940-41 school year, the first of operation of the Benefit Plan, there were 328 member schools with 9,975 registered students. Each year there have been increased school memberships and student registrations until at the present time (January 31, 1947) there are 611 member schools and 25,612 registered students. During the approximately six and one-half years (September 1, 1940—January 31, 1947) of operation of the Benefit Plan in Michigan a total of 6,942 claims have been paid for an aggregate of $107,364.21. At present there are forty-five scheduled benefits which deal largely with fractures, X-Rays, sutures, hospitalization, and concussions as well as dental injuries. Each year an upward revision of scheduled benefits has been effected because there has been no disposition on the part of the Benefit Plan to accumulate other than a reasonable reserve to maintain itself in normal operation of the Plan.

Benefit Plan Procedure

Undoubtedly, many of the members of the medical profession in attendance at this conference have had some experience in the procedures followed when an injury is received by a registered high school student. However, a brief review of the plan may be in order. Schools become members of the Benefit Plan and register their students before coverage is provided. The names of such students, together with a registration card, which includes a physical examination statement by a physician, is forwarded to the Benefit Plan office. When an injury occurs, the school must report it to the Benefit Plan office within fifteen days after it has occurred. Proof of Injury Blanks, one to be filled out and signed by the student and school administrator, and another by the attending physician or dentist, are then sent to the school and the claim is given a number. Normally, sixty days are allowed for the completion of a claim but extensions are granted if more time is necessary. Every attempt has been made to simplify the mechanics of completing a claim on the part of schools, physicians, and dentists. The information requested simply is an attempt to verify the report of injury, as well as the costs involved, and to make available to the Benefit Plan office necessary statistics which are valuable in the possible elimination of future injuries. The Benefit Plans in operation in the various states which now have them, have been and are continuing to co-operate in furnishing valuable information which may be of mutual aid. After the Proof of Injury Blanks are received they are then processed in the Benefit Plan office to see that they are in accordance with the previously reported injuries. A Benefit Plan check for the scheduled allowances is then sent to the principal of the high school concerned and on it the name of the boy, the attending physician or dentist, or the hospital in which service was rendered, are indicated. As stated previously this procedure is required in accordance with the provisions laid down by the State Insurance Department and the Attorney General when the Michigan plan was established. If we dealt directly with students or parents, doctors, dentists, or hospitals, we then definitely would be in the insurance business and required to comply with regulations established for such operation in this state. This would require the establishment of a legal reserve beyond our possibility and also place our organization under complete insurance supervision. At the present student registration rates and schedule of benefits, it would be impossible to operate the Benefit Plan if this procedure were followed.

Annual Revision of Schedules

It has been indicated that schedules have been revised upward each year since the Benefit Plan was established in Michigan. This has been done with a very small increase in registration fees. During the first year of the Benefit Plan, coverage for scheduled injuries and transportation was $1.60 per student for all sports. In 1944 a $50.00 maximum hospitalization benefit was included and coverage for girls was added. The registration fee then became $1.75 and has remained at that figure since that date. For next year we are considering the possibility of using the Michigan Uniform Fee Schedule for Governmental Agencies as adopted by the Michigan State Medical Society. We will have to see what the costs of allowed benefits would have been for this year had the above schedule been used rather than that now in effect. Without being absolutely certain on the matter, however, it is quite apparent that it would be impossible to meet this schedule with the present student registration fee. That doesn't mean, however, that it might not be desirable to raise the student registration fee in order to comply with this schedule. This group may be assured that members of the Michigan State Medical Society will be asked to aid us in the final consideration of any changes in existing scheduled benefits in this connection.

Benefit Plan Summary—1945-46 School Year

It may be of interest to members of the medical profession to have a summary of the complete operation of the Benefit Plan during the 1945-46 school year (from August 1, 1945 to July 31, 1946). The August, 1946, Bulletin of the Michigan High School Athletic Association contains this information on pages 44-71. It includes the report of the auditor, the list of member schools, a summary of allowed injury claims by types of injuries and sports concerned and gives a complete accounting of payments made to all member schools for which injury claims were allowed. This publication is available to any member of the medical profession upon request to the Benefit Plan office.

(Continued on Page 400)

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At meal time his renowned judgment deserts him. Eating only the food he likes, a choice of notably limited range, he thrice daily produces a burlesque on proper nutrition. Inevitably, this perennial first-nighter makes his entrance into some physician's reception room—the victim of a self-made, borderline vitamin deficiency. In the same cast, you will find other familiar types. Included in it are the ignorant and indifferent, people "too busy" to eat properly, those on self-imposed and badly balanced reducing diets, excessive smokers, food faddists and alcoholics, to name a few. First thought in such cases is dietary reform, of course. Along with that, a dependable vitamin supplement may well be in order. When you prescribe an *Abbott* vitamin product, you are assured that the patient will receive the full vitamin potencies intended. Your pharmacy carries a complete line of Abbott vitamin products in a variety of dosage forms and package sizes, and will be pleased to fill your prescriptions. Abbott Laboratories, North Chicago, Illinois.

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Abbott Vitamin Products

(Continued from Page 398)

BENEFIT PLAN SUMMARY—SCHOOL YEAR 1945-46

General Information

Number of Member Schools	509
Number of Registered Students	22,338
Number of Reported Injuries	2,638
Number of Allowed Claims	1,791
Number of Claims Withdrawn	620
Number of Claims Not Allowed	227

School Membership and Registration Fees		$38,209.00
Excess Payments—Interest—Checks Charged off—Withholding Tax		610.74
Total Receipts		$38,819.74
Disbursements:		
Benefit Claims Paid (1,791)	$34,403.30	
Administrative Expenses	4,041.86	
Refunds (Excess Payments)	400.35	
		$38,845.51
Excess Disbursements Over Receipts		$ 25.77

CLASSIFICATION OF INJURIES

(Medical—X-Ray—Hospitalization)

Fractures (538)			$14,418.28
Fractures distributed as follows:			
Leg	106	Vertebra	7
Nose	93	Jaw	5
Hand	91	Cheekbone	3
Arm	83	Skull	3
Clavicle	61	Scapula	2
Foot	37	Pelvis	1
Knee	23	Sternum	1
Ribs	22		
X-Rays—Negative to Fracture or Dislocation (737)			4,663.06
Hospitalization (206)			4,000.35
Dislocations—Complete (94)			1,617.50
Sutures (134)			637.00
Concussions (43)			621.00
Others (Artery—Eye—Kidney—Tendon) (33)			873.75
Non-Scheduled Injuries (45)			4,010.11
Total			$30,841.05

(Dental)

Loss of Tooth (68)	$ 1,339.75
Maximum Dental Injury—More than One Tooth (28)	963.00
Fractured Tooth (79)	768.00
Others (Enamel Fracture—Facings—Restorations) (31)	80.00
Total	$ 3,150.75

(Transportation)

Principal Sum (1)	$ 300.00
Hospitalization (1)	65.50
Medical Care (1)	46.00
Total	$ 411.50

Grand Total Paid on Medical, X-Ray, Hospitalization, Dental and Transportation Injuries	$34,403.30

Number—Average—Percentage of Injuries by Activities

FOOTBALL—1239 Injuries—Average Claim	$20.65
Percentage of All Injuries 69.2%	
BASKETBALL—275 Injuries—Average Claim	13.92
Percentage of All Injuries 15.3%	
BASEBALL—118 Injuries—Average Claim	17.96
Percentage of All Injuries 6.6%	
PHYSICAL EDUCATION AND INTRAMURALS—98 Injuries—Average Claim	17.20
Percentage of All Injuries 5.4%	
TRACK AND OTHERS—61 Injuries—Average	13.84
Percentage of All Injuries 3.5%	
AVERAGE PAYMENT PER CLAIM (1,791 Claims in All Sports)	19.20

NOTE: It is important to realize that injury claims were paid for only one student in twelve or approximately 8.5% of the total number of registered students during the 1945-46 school year.

A few important considerations may be of interest to this group from the above information. It will be noted that there were 737 claims paid for X-Rays which were negative to fracture or dislocation. We feel that this has been a valuable scheduled benefit in that it allows a school and physician to determine definitely whether or not a fracture has occurred and makes the maximum of $7.50 allowable for the determination of such necessary information. Over and above other benefits last year there were 206 hospital claims paid. This payment undoubtedly assured students of better attention than they otherwise might have received had not this allowance been possible. A total of $4,010.11 was paid to member schools for forty-five non-scheduled claims after all regularly scheduled claims had been paid. Of the 1,791 allowed claims during 1945-46, 1,582 were for medical, hospital and X-Ray services, and 209 were paid for dental services.

In conclusion, may I say that the Benefit Plan has appreciated the co-operation it has received from the Athletic Committee and the Executive Committee of the Michigan State Medical Society. We are most anxious to work closely with your organization. Members of the medical profession always have been generous in aiding schools in conducting their athletic and physical education programs. Many services have been rendered by doctors and dentists with little or no assurance that they would be reimbursed. Of course, some professional men have felt that the rendering of such services offered them contacts which otherwise would not be obtainable, but it is our belief that this motive isn't the one which has prompted them to aid in any capacity they could. It probably is quite safe to say that at least 60-75 per cent of the more than $100,000 paid out by the Benefit Plan during the six and one-half years of its operation have been funds which have been realized by the members of the medical and dental professions for services rendered which, prior to the establishment of the Benefit Plan, would have been performed gratis. In that respect we hope we have been of aid to organizations such as yours. It would be remiss, however, not to say that we also believe much more remains to be done on our part.

Future Possibilities

At a recent meeting of the Athletic Committee of the State Medical Society it was suggested that considerable could be done to acquaint both the school men of your respective counties and members of your Association with the best procedures to be followed in connection with the reporting and attention to athletic injuries. It has been proposed that meetings of school administrators and medical men of each county be arranged at which some of the matters that have been troublesome in regard to athletic injuries could be discussed. The officers of the Benefit Plan, which includes representatives from our office as well as the five school men who are members of the Administrative Committee, will be glad to aid in any capacity in this connection. While the number of member schools is approximately twice that of the first year that the Benefit Plan was established in Michigan, and the number of registered students is approximately three times the original number, we still feel that we have only made a modest beginning in the amount of service possible to render. We solicit the continued co-operation of the Michigan State Medical Society and pledge our best efforts as school men to aid in furthering this most important project which concerns members of your profession, that of dentistry, school patrons, and above all, the lad who may be injured while participating in athletics or physical education.

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National Conference On Rural Health

R. J. Hubbell, M.D., Councilor of the Fourth District, Michigan State Medical Society, reports on the Rural Health Conference held in Chicago, February 7 and 8, 1947. The following excerpts are given for the benefit of our readers.

Mr. Albert S. Goss, Master of the National Grange, brought out the fact that the average farmer's income is from $500.00 to $700.00 less per year than the urban dweller's. The average number of doctors of medicine per population in the country is about one to 1,700. There are too few hospitals and far too few doctors, and that is why the rural people are concerned. Figures on the accidental death rate on the farm were rather interesting—the quoted figure was 53 per 100,000 as compared to 19 per 100,000 for the city dweller, Discussion brought out the fact that farm boys examined for the draft were not as fit as the urban boys.

It was felt that the rural people are very much concerned about health matters, and are sincerely looking to the doctors for a solution. It was noted that farmers are talking a great deal about co-operatives. They of course, have been interested in this sort of thing for many years, and naturally tend to think along these lines when it comes to medical care. However, we all know that Michigan Medical Service may be considered a co-operative.

F. A. Humphrey, M.D., of Fort Collins, Colorado, chairman of the Committee on Rural Health, reminded his audience that it is the duty of the local people to make their rural vicinity attractive to physicians, even if it is necessary for them to be subsidized. Throughout the conference the things that were stressed as community attractions for physicians were good roads, good schools, good homes and theatres, and adequate place for the physician to work (such as a health center or small hospital) and especially an increase in the income of the farmer. He strongly suggested residencies in hospitals for general practice, plans for which have already been made in Colorado. He also voiced an opinion that many have held for some time, that specialty boards require some general practice—say two or three years—as a requisite for certification. It would seem that this would tend to expose more men to general practice, with the result that more men would take it up. Then, too, it would tend to favor the general practitioner returning for specialty work, which is now a difficult thing to do, and in the end it would make for a better specialist. He felt that the general practitioner in the rural communities should be allowed to follow his cases to the neighboring hospitals.

Mr. Chester Starr, Director of the Missouri Farm Bureau Federation, Rural Health program, spoke on a little more optimistic note, stating that there are 39 per cent more doctors in rural areas since the war. He reiterated the things that attract doctors to rural areas. He thought that doctors should place more emphasis on general practice, and that there should be more co-operation by the doctors in public health matters. He thought that medical prepayment plans should be encouraged, and doctors should co-operate in them.

Mrs. Roy C. F. Weagley, president of the Associated Women of the American Farm Bureau, was of the opinion that lack of facilities means lack of medical service, and that if more rural health centers were set up, there might be a resultant reduction in the need for a good deal of expansion of hospitals in the urban areas.

R. C. Buerki, M.D., of the Graduate School of Philadelphia, gave a very forceful talk. He felt that the rural people do not want simply more medical care of a poor calibre, but that they want more medical care of a good calibre. He thought we should be sure that the new hospitals can be supported financially to attract the best doctors. He agreed that general practitioners should be allowed to be on hospital staffs, but that they should also realize their limits of practice.

Mrs. Edwards of the Co-operative Union of America unequivocally favored compulsory health insurance.

Mr. J. S. Jones, Executive Secretary of the Minnesota Farm Bureau, felt that voluntary medical care plans are no longer an experiment, and that more selling is required. He gave figures of overhead cost which varied from 22 per cent to 87 per cent. He did not give the source of those figures, but they are certainly high compared to that of Michigan Medical Service, which is around 11 per cent. He felt very strongly that the farmers do not want the United States in business.

In the afternoon of the first day the members of the conference divided into groups for different round-table discussions. Your representative attended the one on Voluntary Medical Pre-Payment Plans. There seemed to be quite an interest expressed in pre-payment plans. The main interest, however, was in seeing that the farmer is able to buy it. It was felt that at the present time it is very difficult for the farmer to do so. It was the general opinion that pre-payment plans should cover the entire community, and not just certain groups. This opinion was voiced especially by Mr. Michael Davis. It was felt that a plan should probably be developed on a statewide level, and the need of a broad educational program and enrollment was stressed. It was thought, in general, that all forms of funds should be used to develop facilities. Special concern was voiced not about the indigent, but about the marginal person—the one we would classify in our community as "medical indigent." There was some question as to how he would be taken care of under pre-payment plans.

Saturday morning there was a summary of the reports from the different discussion groups. The group on hospital facilities thought the definition of "facilities," should be clarified, and this seemed to be a good idea.

It was suggested that a hospital of less than fifty beds could not be run economically. A man from Iowa,

(Continued on Page 404)

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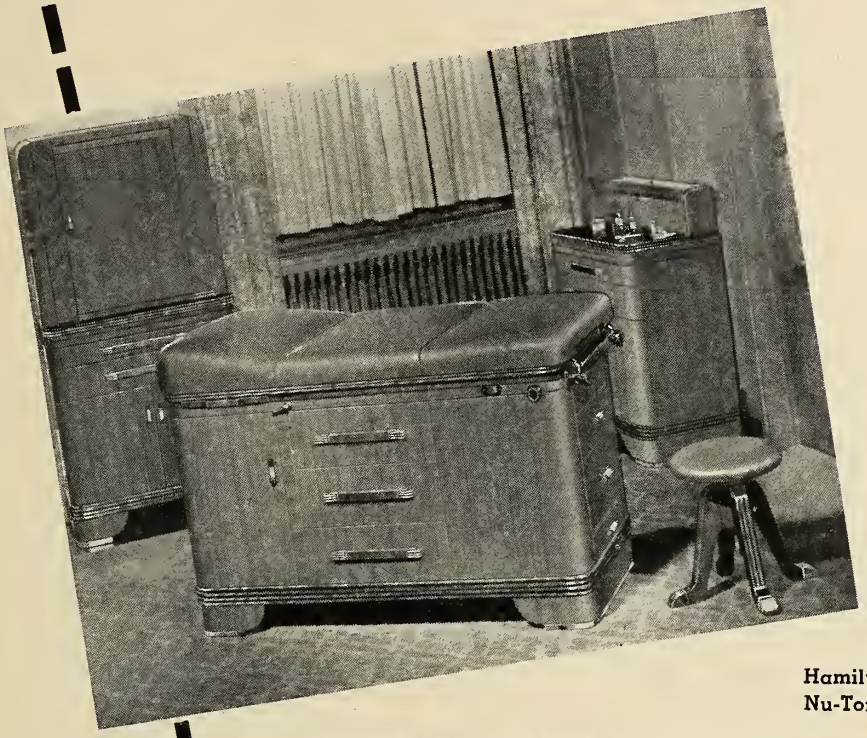

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(Continued from Page 402)

however made a strong plea for a small ten to twenty-bed hospital in the rural community to afford a place for minor surgery and obstetrics.

The discussion on bringing in and holding physicians in rural areas recommended State Health Councils. In our state this would mean a revision of our present Health Council with the stressing of health education in the schools, and a course of medical economics in medical schools, which fortunately we are trying out in Michigan. They thought that whatever is done in rural communities should not follow county lines, but should be on a community basis, as farmers do not act in county units primarily.

Discussion of certain needs brought out the fact that there is going to be a continued shortage of nurses because of low registration in classes, and that practical nurses are urgently needed and should be encouraged. A man from Duluth, Minnesota, felt that nurses should be trained in our rural hospitals and perhaps affiliated with the larger hospitals.

The discussion of Health Councils occupied the time of the whole discussion group, and apparently they were thought to be of very much value.

The group on medical care for lower income groups included a large field, and some very interesting information developed. One point of interest was that the lower income group probably represents about 85 per cent of the rural population. If that is true, then our job is a big one.

INTERN-RESIDENT PARTY ON JUNE 4

Detroit Receiving Hospital will honor interns and residents at the annual banquet Wednesday evening, June 4, 1947, at the Statler Hotel, Detroit, Michigan.

All former interns and residents of the hospital are cordially invited to return for the banquet, and are asked to write to Dr. James J. Lightbody, chairman of the Banquet Committee, in care of Detroit Receiving Hospital, for tickets—price $6.50—while they last. The ticket price includes cocktails, dinner and entertainment.

WAGNER-MURRAY-DINGELL

(Continued from Page 392)

per cent of the population. The benefits will be hospital care and services of a physician to hospitalized medical, obstetrical and surgical patients. The tax levy will be two and a half per cent upon wages, salaries and dividends up to $5,000, divided equally between employers and employes. The commission admits that the services are to be "the beginning of an orderly progress through organized payments to the goal that all of the benefits of the medical sciences shall be available to all the people of the Territory according to their needs."

Hawaii is soon slated to became a state, and the socialized medicine crowd seem to think now is the time to get their scheme established, when it is not a question of the will of the people so much as it may be a question of the will of those who are shaping the plans and arrangement for statehood.

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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60; Proc. Soc. Exp. Biol. and Med., 1934, 32, 241; N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.*

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MSMS Annual Session — Grand Rapids
September 23-26, 1947

TECHNICAL EXHIBITS

Name	Booth
Abbott Laboratories, Chicago, Ill.	C- 5
A. S. Aloe Co., St. Louis, Mo.	A-10
Ames Company, Inc., Elkhart, Ind.	D- 6
Ayerst, McKenna & Harrison, Ltd., New York, N.Y.	E-10
Baker Laboratories, Cleveland, Ohio	B- 4
Bard-Parker Company, Inc., Danbury, Conn.	C-18
Barry Laboratory, Detroit, Mich.	D- 5
Becton, Dickinson & Co., Rutherford, N. J.	D-12
The Borden Company, New York, N. Y.	B-18
Brewer & Company, Inc., Worcester, Mass	E-12
Brooks Appliance Co., Chicago, Ill.	D-15
Burroughs-Wellcome & Co., Inc., New York, N. Y.	C- 2
Camel Cigarettes, New York, N.Y.	A-11
Cameron Heartometer Co., Chicago, Ill.	C-22
Cameron Surgical Specialty Co., Chicago, Ill.	D-21
Carnation Company, Oconomowoc, Wisc.	A- 3
Ciba Pharmaceutical Products, Inc., Summit, N. J.	E- 7
Coca-Cola Company, Atlanta, Ga.	A-16
Davis & Geck, Inc., Brooklyn, N. Y.	A- 8 and Cinema Room
DePuy Mfg. Company, Warsaw, Ind.	E-20
Detroit Creamery Co., Detroit, Mich.	D-10
Detroit X-Ray Sales Co., Detroit, Mich.	E-17
Doho Chemical Corp., New York, N. Y.	C- 7
Eaton Laboratories, Inc., Norwich, N. Y.	E-13, E-15
The Ediphone Company, Grand Rapids, Mich.	D-13
Ethicon Suture Labs., New Brunswick, N. J.	C-16
H. G. Fischer & Co., Chicago, Ill.	D-18
C. B. Fleet Company, Inc., Lynchburg, Va.	C-20
General Electric X-Ray Corp., Chicago, Ill.	A- 7
Gerber Products Co., Fremont, Mich.	B-10
Otis E. Glidden & Co., Inc., Evanston, Ill.	E-14
Hack Shoe Company, Detroit, Mich.	E- 8
Hanovia Chemical & Mfg. Co., Newark, N. J.	C- 4
J. F. Hartz Co., Detroit, Mich.	B-20
H. J. Heinz Co., Pittsburgh, Pa.	D-22
Hoffmann-La Roche, Inc., Nutley, N. J.	C-10
Holland-Rantos, Inc., New York, N. Y.	E- 2
G. A. Ingram Co., Detroit, Mich.	C-13, C-15, C-17
"The 'Junket' Folks," Little Falls, N. Y.	D-17
H. W. Kinney & Sons, Inc., Columbus, Ind.	E- 1
A. Kuhlman & Co., Detroit, Mich.	A-14, A-15
Lea & Febiger, Philadelphia, Pa.	B-16
Lederle Laboratories, New York, N. Y.	D-16
Libby, McNeill & Libby, Chicago, Ill.	D- 7
Liebel-Flarsheim Co., Cincinnati, Ohio	C- 8
Eli Lilly & Company, Indianapolis, Ind.	B- 8
J. B. Lippincott Co., Philadelphia, Pa.	A-13
Liquid Carbonic Corp., Chicago, Ill.	D- 9
M & R Dietetic Labs., Columbus, Ohio	E- 3
McKesson Appliance Co., Toledo, Ohio	D-14
Mead Johnson & Co., Evansville, Ind.	A-4, A- 5
Medical Arts Surgical Supply Co., Grand Rapids, Mich.	C-1, C- 3
Medical Case History Bureau, New York, N. Y.	C-19
Medical Film Guild, New York, N. Y.	A- 6 and Cinema Room
Medical Protective Co., Fort Wayne, Ind.	B- 2
Merck & Co., Inc., Rahway, N. J.	D-11
Wm. S. Merrell Co., Cincinnati, Ohio	A- 2
Michigan Medical Service, Detroit, Mich.	B- 5
C. V. Mosby Co., St. Louis, Mo.	B- 6
National Dairy Council, Chicago, Ill.	E- 6
National Drug Company, Philadelphia, Pa.	E- 4
Wm. R. Niedelson, Detroit, Mich.	C- 5
Ortho Pharmaceutical Corp., Linden, N. J.	D-19
Parke, Davis & Co., Detroit, Mich.	B-7, B-9, B-11, B-13
Pet Milk Company, St. Louis, Mo.	B-12, B-14
Philip Morris & Company, Ltd., New York, N. Y.	E-21
Picker X-Ray Corp., New York, N. Y.	D-2, D- 4
Pitman-Moore Company, Indianapolis, Inc.	A- 9
Procter & Gamble Co., Cincinnati, Ohio	E-18
Professional Management, Battle Creek, Mich.	E-22
Radium Emanation Corp., New York, N. Y.	E-11
Randolph Surgical Supply Co., Detroit, Mich.	B-15, B-17
W. B. Saunders Co., Philadelphia, Pa.	D-20
Schenley Laboratories, Inc., New York, N. Y.	B- 1
Schering Corporation, Bloomfield, N. J.	A- 1
G. D. Searle & Co., Chicago, Ill.	D- 1
Sharp & Dohme, Inc., Philadelphia, Pa.	A-12
Smith, Kline & French Labs., Philadelphia, Pa.	E- 5
Spencer Incorporated, New Haven, Conn.	C- 9
E. R. Squibb & Sons, New York, N. Y.	D- 8
Frederick Stearns & Co., Detroit, Mich.	D-3
VanPelt & Brown, Inc., Richmond, Va.	E-16
Westinghouse X-Ray Company, Detroit, Mich.	C-12, C-14
White Laboratories, Newark, N. J.	B- 3
Winthrop Chemical Co., Inc., New York, N. Y.	C-11
Zimmer Mfg. Company, Warsaw, Ind.	E-20

GENERAL OUTLINE OF 1947 MSMS ANNUAL SESSION

Civic Auditorium—Pantlind Hotel, Grand Rapids

	Tues., Sept. 23	Wed., Sept. 24	Thurs., Sept. 25	Fri., Sept. 26
9:30 to 11:50 a.m.	(Final meeting of House of Delegates)	General Assembly (4 periods)	General Assembly (4 periods)	General Assembly (4 periods)
12 Noon to 1:30 p.m.	2 Section Meetings	4 Section Meetings	5 Section Meetings	1 Section Meeting Discussion 3 Conferences (12 to 2 p.m.) (Incl. luncheon)
1:40 to 4:25 p.m.	General Assembly (5 periods)	General Assembly (5 periods)	General Assembly (5 periods)	
4:30 to 5:30 p.m.	Discussion Conferences	Discussion Conferences	Discussion Conferences	End of 1947 Annual Session
8:00 p.m.	Alumni and Fraternity Dinners	Officers' Night	State Society Night	

The JOURNAL

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The Physician and the State

By Kim Sigler, LL.B.

Governor of Michigan

I recall an occasion during my campaign when I attended the church of Dr. Ross. I have known him for some time and he is a very pleasant gentleman. I went to his church to attend the entire service. I wanted to understand a little better certain feelings and impulses. On that particular morning the good pastor was delivering a sermon against indulging in arguments.

To illustrate his point he said that no man should argue with his brother or neighbor but should sit down and reason. He said husbands and wives should never argue because "you just can't win." Finally, he said, he recalled very distinctly when two members of his congregation, who had argued a long time whether a certain gadget was scissors or clippers, came in to see him. The husband contended it was the latter. Finally he said to her, "If you call them scissors once more, I'll take you out of the back door and dunk you." Again the wife said they were scissors. When she had been dunked three times, the wife raised her two fingers. Gentlemen, you can't win.

Being governor of a big state is indeed an interesting experience. I have now been governor for a month. Every morning there come into my office over 500 letters. My staff tries to please me by saying that is about twice as many as others have received. The letters are on every subject under the sun—from asking for a job to telling me what is wrong with various things.

There are many requests to appear before groups. I have had to make certain inquiries about these requests. So when I received a request from your president to speak to this group, I started to inquire about it. I know of the reputation of your president, Dr. Carr—he has an inestimable standing in the community. I know also of the fine standing and reputation of President Hyland of the Michigan State Medical Society. Aware of the high repute of the individual members, I then began to inquire just what you do for us, the public. I sent one of my administrative assistants to find out, and I was very pleased at what I learned. I have been interested in groups for such purposes for some time, since socialized medicine was one of the subjects I was interested in. Another subject had to do with the future of Michigan, in which you also are interested. I have long believed that Michigan has not been sold in the manner it should be. Then I found in the brochure you had sent me the purposes of your organization.

Let us think of that for a moment. I remember very distinctly when I graduated from law school. A group of us walked back from school to the fraternity house and one of the men who had just received his degree said, "Well, I guess we are all set." I wondered if we were. It looked to me as if we had just begun, had just acquired the tools. The next step was to go out and learn what law really was.

I wonder if that is not true for you, too. We have all seen the doctor, lawyer, or dentist who, when he had received his degree, sat back in smug complacency, tried to go along and not keep abreast of developments in his field. Therefore, I am very much interested in the purposes that

Address before the Michigan Foundation for Medical and Health Education, Detroit, Michigan, February 2, 1947.

brought us together today. "This corporation is organized and shall be operated exclusively for benevolent, scientific, and educational purposes."

Some time ago, one morning in this hotel, I had breakfast with Mr. Charles Kettering, the great wizard of invention who is employed by one of the great corporations. He has scientific insight and is a remarkable person. We were sitting having breakfast, talking about government. I asked why we don't always have better government and why the government so frequently makes the same mistake that was made some years ago.

Mr. Kettering made this significant statement: "Whenever we start to determine what we want to do in a particular direction, whether it is building an automobile, development of a motor, or other phase of industry, in our laboratory we catalogue everything we have done. We list every item that we do. We make a history of it. Then if we fail and do not arrive at the proper results, we go back and do it differently. Did you ever stop to think that in government you never do this?"

Then we discussed some of the mistakes that have been made down through the centuries by people and government. So frequently have our administrators followed the same course that has been experienced generations ago. I am very much interested in that we try to keep in mind what has been done and try to do it better. Of course, that is a general rule for a lawyer, as a lawyer never tries a law case until he looks up the precedent. Perhaps he ascertains what bit of evidence most impressed the jury or the court. What did the lawyer on the losing side do wrong? In similar thought, the doctor, the dentist, the banker doesn't have the same answers when confronted with the same situation.

Let us think about socialized medicine. It is a most important subject, because it is important in the lives of people. I am going to approach the matter in what I think is a practical, general way. If I should tell you how to handle medical matters, I should be thought presumptuous. Frequently through the generations people have become all stampeded about some procedure and have gone overboard regarding some foolish proposition. Do you remember the history of France—how certain individuals started out a certain bonding that resulted in senseless inflation and then a crash? Do you recall many such incidents in our own country, and the many problems that related to foolish propaganda that people did not take time to understand?

Let us apply a little of that to socialized medicine. In my mind the people who should determine the state's interest in medicine are those people who are qualified to judge—not some politician, not some writer. The judges should be yourselves. You should be able to say how much the state should do. Nobody wants to see the state practice medicine.

In the main, I am definitely opposed to socialized medicine; just as I would be opposed to the regimentation of the legal profession. You, who are experts on the subject, should be the ones to tell it fairly, frankly, honestly, and see that the people understand the need and facts and act accordingly. This is what I am going to do.

I have a surprise for you. I believe in dealing with all these matters in a very practical manner. Mr. Richards, Manager of WJR, together with powerful stations in Cleveland and Los Angeles, told me, "Listen, if you are really going to do all the things you say, I am going to offer you my microphone, on your desk, to tell the people in the state what you are doing." I said, "All right, let's try it." After we had it started, another station came along and offered me another setup. I now broadcast from the Governor's Office every other Saturday night at 7 P.M. over WJR and every other Wednesday over WWJ.

Last night I asked Dr. Hannah, president of Michigan State College, to come to my office so that we could tell the people about problems of that college—large enrollment, large number of married students, 1,500 babies. The average person has no conception of its problems.

I want to offer you an opportunity to let the people of Michigan know what you are doing and let the people know what should be done on the subject of medical health and education. Education is necessary as it relates to the people. I have promised the people that I will let them know about government and what affects government. I'd suggest that Dr. Carr work out a program that will be fair, instructive, and informative.

What does the average person of Michigan know about socialized medicine? It sounds good. They believe doctors are against it because they are selfish. I know that is ridiculous, silly. I know that from various angles. The same misinformation exists about lawyers, too. For instance, recently someone asked me, "Why don't you do

something about all those persons executing deeds, the notary public who handles thousands of dollars of the life savings for people?" The criticism was that the lawyers are trying to corral all the business. However, the greatest business comes when a lawyer draws up the wrong kind of deed! If the people just fully understand, they will always arrive at the right results. I have great confidence in the average citizen when he knows the facts but I have little confidence if he does not know the facts.

Once when riding in London, I got in an argument about democracy and the English system. I made what I thought was a stout defense. The Englishman finally said, "The Americans never think—they just have opinions." Do we do that today? Are our people just jumping at conclusions? Let us see that they don't. Let us find a method by which they can fully understand these things; let us see that there is no danger that some foolish notion sweeps over the land.

Let us approach this question from another angle. During my campaign I was all over Michigan—in all eighty-three counties. We traveled many thousands of miles. One thing impressed me: the lack of government consciousness on the part of the people in general, the tendency to become so interested in their own little spheres that they do not realize that other people have problems, too.

In the Upper Peninsula, people feel isolated from the rest of Michigan. They transact business with Milwaukee, carry on nearly all their economic life with Wisconsin and Minnesota and think of Michigan only in terms of its political side. They feel that they are not really a part of Michigan. They are of the opinion that, in settling the boundary dispute with Ohio, a mistake was made, that rightly they should be a part of Wisconsin. Let us try to see what the reason is. The average man who runs for office makes a lot of promises he forgets, about linking the two parts of the state. Or as another example, if a lawyer has to go to Lansing to argue a case for fifteen minutes, and doesn't want to drive, he must travel through three states unless he takes a circuitous, inconvenient route. There must be some method of getting those people a little closer to the other parts of Michigan, and we all should be interested in finding the answer. What does that have to do with you?

For one thing, whatever affects the welfare of one person or group, affects every other person or group. Last year four and a half million dollars was left in the State of Michigan by tourist business. It is the second largest business in Michigan and its further possibilities are enormous. For instance, the winter sports resources of upper Michigan have been barely touched, although the great ski tournaments are a start in the right direction. The people of Michigan should be sold on Michigan, and they are not.

I was amazed at a particular spot in the southwest corner of the state, that very fine community of Benton Harbor. While I was visiting there, a friend called, "Come out and see what we did with the city dump." It had become a very fine market; it is the world's largest fresh fruit market. Last year it did between an eight and ten million dollar business. How many of us know about it? The average citizen doesn't know it. In Macomb County, where they have fine stump fences like antlers, is located the potato center of the world. They produce more potatoes there than any place, except Maine. They raise the seed potatoes for Maine. It is the great product in Macomb County. And yet, last summer I walked into a store in the very heart of Michigan and they were selling Idaho potatoes.

Can we sell Michigan as we should to the people Michigan? In the selling of Michigan one of the important factors is medicine, public health—the very thing you are doing. If you get behind the situation and put your shoulder to this work, you can contribute in a large measure to making Michigan outstanding in this field. It will take time, hard work, and effort. As the governor of this state, I am willing to help you.

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ATOMIC FISSION PRODUCTS DAMAGE BRAIN TISSUES

Beta rays, which are among the products of atomic fission, can do serious damage to the tissues of the brain, Dr. Rosalind Novick of the University of Minnesota School of Medicine reported before the meeting in Montreal of the American Association of Anatomists.

She had made a close examination of injuries done to the brains of cats by beta rays given off by radium. The injuries were in sharply limited spots, with zones of decreasing severity as the distance from the ray sources increased. At the center there was dead tissue, then a zone of shrunken and darkened nerve cells, then cells that were acutely swollen, and finally uninjured tissue.—*Science News Letter,* April 12, 1947.

The Operation of Public Law 725

Hospital Survey and Construction Act

By Herman E. Hilleboe, M.D.
Assistant Surgeon General, USPHS

To those of us in the health and medical profession, the signing of the Hospital Survey and Construction Act was an event of great significance. It meant that American medicine, engaged in the fight to bring good health and medical care to all the people, would be better equipped with the hospitals and health centers needed to do the job. You in this audience have long been aware of our shortage of health facilities. That this shortage is clearly recognized by the states is evident from the action they have taken since the passage of this legislation. In less than six months thirty-three states have applied for Federal funds to conduct surveys of hospital facilities. Many of the states have already passed legislation relating to the program, while most of the others are presenting hospital bills of some type in their current legislative sessions. We can appreciate the importance of this action when we realize that the 375 million dollar Federal grant must be met by the states on a two-to-one basis.

The history of the Hospital Survey and Construction Act is a striking example of the power of concerted action in a democratic nation. In 1943 the American Hospital Association resolved to seek Federal aid in building needed hospitals. This was the first of many spontaneous efforts that resulted in the introduction of Senate Bill 191, under the sponsorship of Senator Lister Hill of Alabama and Senator Harold Burton of Ohio.

During Congressional hearings on the bill, many professional and citizen groups came forward to support it. The American Hospital Association, the Catholic Hospital Association, and the Protestant Hospital Association joined forces with the major farm and labor organizations, organized medicine, dentistry and nursing, to advance this legislation. Many other groups and individuals of national importance also helped. The bill became Public Law 725 when it was signed by the President on August 13, 1946.

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Under the Hospital Survey and Construction Act, the United States will be engaged in the most comprehensive hospital program ever undertaken by any nation. The broad purpose of the legislation is to assist states in planning for and providing hospitals and health centers distributed geographically in proportion to need. We are all aware of the uneven distribution of health facilities in the United States. In spite of the real progress that has been made in raising the standards of health in our nation, there are still many serious gaps. American medical care at its best is the finest in the world, but there are many areas of our country, many groups of our citizens, to whom the best is not available. We find the best-equipped and most abundant facilities concentrated in the wealthiest states and in metropolitan areas, and the least adequate facilities in rural and economically distressed areas. In approximately 40 per cent of the nation's 3,000 counties, representing 15,000,000 people, there are no registered hospitals. Many of the hospitals that are registered today fall far below standards that could and should be achieved. The lack of public health facilities is equally disturbing. Approximately 40 per cent of the counties have no full-time public health services. And altogether too many of the others have so-called public health centers housed in cellars or courthouses, in condemned buildings, and in other undesirable locations. Not only are these centers badly located; they are so poorly equipped, for the most part, that instead of helping, they handicap public health officers.

As its name implies, the Hospital Survey and Construction Act has two main purposes. First, it provides assistance to the states in surveying overall state needs and in making master plans for needed hospitals and health facilities. Second, it provides assistance for the next five years in the construction necessary to carry out these plans.

To accomplish this two-fold aim, the Act authorizes an initial Federal appropriation of $3,000,000 to assist with the surveys, and then $75,000,000 annually for the five-year period, starting July 1, 1946, to assist with construction. To date, $2,350,000 has been made available for the survey and planning phase of the program.

It will be the responsibility of the present Congress to make the initial appropriation for construction. In view of the time needed for the survey and planning, it was not expected that the full $75,000,000 authorized for construction the first

fiscal year could be utilized by June 30, 1948. Therefore, construction appropriation of $50,000,000 has been requested for the first year and approximately $100,000,000 will be asked for the second year.

Under the program, hospitals, public health centers, and related facilities may be constructed. By "hospitals" are meant general, tuberculosis, mental, chronic disease, and other types, but not those that furnish primarily domiciliary care. Funds for construction may be granted only to public and nonprofit hospitals. Proprietary hospitals are excluded. A "public health center" is defined as a publicly owned facility for providing public health services, the scope of which is a matter of state law.

"Related facilities" include laboratories, outpatient departments, nurses' homes, training facilities, and clinics.

The term "construction" is broadly defined to include: construction of new buildings; expansion, remodeling, and alteration of existing buildings; and initial equipment for any such new or existing facilities.

It should be emphasized that the Hospital Survey and Construction Act does not follow the pattern of the usual Federal works program. It is solely a grant-in-aid program. It delegates the major of responsibility to the individual state. A single agency of the state government will administer each phase of the program, and a state advisory council, composed of technical and consumer representatives, will participate actively.

Federal administration of the program is the responsibility of the Surgeon General of the United States Public Health Service, assisted by the Federal Hospital Council and its advisory committee. The Council consists of eight members, four of them outstanding in hospital and health activities, and four representing consumers of hospital services.

One of the primary responsibilities of the Federal Administration is the formulation of regulations. The Act authorized the Surgeon General, with the approval of the Federal Hospital Council and the Federal Security Administrator, to establish these general regulations within six months after the signing of the Act. The regulations have been prepared and will soon be available. They cover such matters as size, distribution, and types of hospitals that may be constructed, construction standards, services for all persons regardless of race, creed or color, and service for those unable to pay. The regulations also set up methods of determining priority of projects to assure that hospitals will be built on the basis of relative need.

Within the United States Public Health Service, the responsibility for assisting the Surgeon General in the administration of the Act rests with the newly created Division of Hospital Facilities. The four major offices in this division are the Office of Program Planning, the Office of Program Operations, the Office of Technical Services and the Office of Hospital Services.

The Office of Program Planning develops general methods of improving hospital and health standards, and conducts orientation programs for Public Health Service personnel and for personnel of state agencies.

The Office of Program Operations formulates, interprets, and carries out regulations and procedures, analyzes applications for funds, and serves as liaison with the field through District Offices of the United States Public Health Service.

The Office of Technical Services develops standards and plans covering the architectural phase of construction, and reviews designs, blueprints, and construction details submitted by applicants.

The Office of Hospital Services develops standards and plans covering administrative phases of hospital services, maintenance and operation.

In order to insure a decentralized approach to this program, the Division of Hospital Facilities works largely through the district offices of the United States Public Health Service. Personnel with specialized training will be assigned to each district office and will include hospital consultants, hospital architects, construction engineers, and hospital administrators. The staff of the district office will in turn work closely with state agencies, communities and organizations on every phase of the program. Application for survey and planning funds and for individual construction projects will all be handled by the district offices.

The Public Health Service in Washington is deluged with inquiries asking "How can we get a hospital in our town?" The answer to this question is embodied in the Act itself. To receive funds for survey and planning, a state must designate an official agency to conduct the work, and must appoint an advisory council to assist this agency. The council must have some members who represent organizations or groups doing hospital work that are not part of Federal, state or local governments. The state then obtains an application for funds

from its Public Health Service district office—for Illinois it would be the Chicago office—and submits it to the Surgeon General. Upon the approval each state is entitled to receive Federal aid for one-third of its survey and planning expenditures, provided, of course, that this amount falls within the state's allotment. These allotments for survey and planning are made to the states on a relative population basis. For example, it has been estimated that out of the three million for survey and planning, the allotment for Illinois would be $172,752.

When a state has completed a comprehensive survey of all hospitals and related facilities, the next step is to draw up a master construction plan designed to meet the needs revealed by the survey. This plan, which must conform with the regulations issued by the Surgeon General, will be administered by the state agency. This may be the same state agency that conducted the survey or it may be a different agency appointed for the purpose.

The Surgeon General is authorized to approve any plan which fulfills these requirements. Should he disapprove a plan, the Federal Hospital Council must grant the state agency a hearing. If the Council decides that the plan complies with requirements, the Surgeon General must then accept the ruling of the Council.

Once the state construction plan is approved, the state enters upon the second phase of the program, the actual building of hospitals, health centers and related facilities. While survey funds are based on state population only, construction allotments are determined by a formula based on two factors, population and per capita income. This formula is weighted in such a way that states with low per capita incomes, where there is a relatively greater need for hospitals, receive more money per capita than do the wealthier states. Out of the first seventy-five million, the construction allotment for Illinois is estimated as $2,771,175, whereas North Carolina, a less populous state with a lower per capita income has an allotment of $3,432,825.

To receive construction funds, the state, public or nonprofit group applies through its state agency to the United States Public Health Service. This project, of course, must have been included in the state construction plan. The application must contain plans and specifications for the proposed facility, assurance of financial support for construction, and for maintenance of the facility when completed. When this application has been approved, Federal funds to meet one-third of the construction costs may be granted. If the Public Health Service finds later that a state agency is not complying with the provisions of the Act, or that funds have been diverted from the purpose for which they were allotted, payments may be withheld, provided that the state agency has been granted a hearing. In this case the project applicant may appeal to the United States Court of Appeals.

With this brief summary of the Act, one can readily see the problems that lie before us. Though all concerned regard this Act as a long step forward in health legislation, nevertheless, we should not overlook its limitations. Even when Federal funds have been matched by non-Federal funds, totalling $1,125,000,000 for the five-year program, it will be possible to provide only about one-fourth of the nation's needs for new and replacement health facilities. Even before the war, when building costs were 50 per cent less, the estimate for meeting these requirements was approximately $4,000,000,000. It is obvious that the present funds, substantial as they are, can carry out only in part the purpose of the Act.

Another serious limitation is the formula for the distribution of Federal funds. All states, regardless of ability to pay, must meet Federal construction funds on a two to one ratio. Clearly, the need is greater in some states than in others. And in states where the need is most pressing, the per capita income is generally lower.

The limitations of this program do not attenuate the many significant and forward-looking features. First among these is the requirements that each state survey its existing hospital and health facilities and develop a construction plan based on the survey. This procedure means that for the first time we are building our hospitals according to a long-range plan. In the past they often cropped up here and there with little or no over-all planning. In some areas there were too many; in most areas too few. Just after World War I, there was a boom in hospital building. By 1928, there were more hospitals registered in the United States than ever before or since. In the following ten years, several hundred went out of existence. The consequent tremendous loss in terms of money and potential services was probably due to lack of careful planning. The present Hospital Facilities and Construction Program provides real assurance that this will not happen again.

Another excellent feature is the requirement for

minimum standards for hospital maintenance. All states must have a licensing law within two years after passage of the Act. In some states this will take the form of a model licensing act; in others these standards may be incorporated in general health legislation. In some states these standards will probably be high, while in others they will be barely adequate. Nevertheless, the philosophy behind this requirement is sound and should lead us to higher standards of hospital care.

Finally, I should like to emphasize once more one of the strongest principles embodied in the Act, namely the decentralization of this program. This is not a Federally dominated program. It is a state program, a community program. The Federal role is largely one of guidance and assistance. To the state and the communities go the responsible task of carrying out the actual operation. Moreover, in its advisory phases the program requires both consumer and professional assistance. Just as the Public Health Service is required by law to have a Federal Hospital Council, so the state agencies administering the Act must have advisory councils to help them. These councils must be representative, not only of the medical and hospital fields, but also of the consumers of such services. In this way we achieve democratic community responsibility in its successful operation, for only if the community provides leadership and accepts full responsibility will the program succeed.

To you, as representatives of the medical profession, falls a good part of this responsibility. Your community looks to you to guard its health. It looks to you for help and guidance in its hospital planning, and it is to you also that we in the Public Health Service are looking for the co-operation and understanding that will be necessary if this program is to fulfill, even partially, the purpose that has been set for it—to provide the people of this country with the hospitals and health facilities needed to enjoy to the fullest the American way of life.

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STATISTICS—MICHIGAN MEDICAL SERVICE

During the first nine months of 1946, the subscription fees earned were $4,597,775.89 and the services rendered were $3,734,183.01, or 81.22 per cent. The administration expense was 11.95 per cent. The reserve for contingencies as of September 30, 1946, was $1,040,204.33. Up to that date there had been paid to doctors $17,167,394.15. Accounts receivable from the Veterans Administration was $168,152.33.

Modern Influences in Medical Practice

By Thomas P. Murdock, M.D.
Meriden, Connecticut

The subject "Modern Influences in Medical Practice" is timely. With the possible exception of the question of compulsory medical care, in my opinion it is the most important subject confronting medicine at this time. Hand in hand with the sub-headings which have been outlined at this conference goes the problem of "Hospital Staff Organization."

There are many suggested plans for hospital staff organization. Chief among these are the plans recommended by the American College of Surgeons and the Commonwealth Foundation.

My suggested plan for hospital organization would be a board of directors elected from the corporators. The directors would select an executive committee. The directors would appoint a medical board made up of a chairman, vice chairman, secretary, and the chiefs of surgery, medicine, obstetrics, and, in the case of large hospitals, the heads of other important departments.

The directors would name annually, upon the recommendation of the medical board, the active and consulting staffs. Courtesy privileges would be granted in the same manner.

The medical board would also recommend the appointment of an intern committee, a program committee, a record committee and such other committees as are deemed necessary for the proper administration of the scientific work of the hospital.

Probably the most important of these committees is the program committee. This committee could do much to stimulate the interest of the staff and house officers with educational programs. A plan should include medical rounds, surgical rounds, weekly staff conferences, clinical pathological conferences and monthly staff meetings. The house officers should be given their proper places at all of these conferences. Eductional programs are absolutely essential, and the hospital that is careless in this regard cannot long survive as a hospital privileged to train interns.

The medical board would recommend to the di-

Dr. Murdock is chief of staff of Meriden Hospital, Meriden, Connecticut.
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rectors, and aid the manager in the selection of, such full-time or part-time physicians as are necessary for the proper administration of the scientific departments in the hospital. This refers particularly to the selection of radiologists, pathologists and anesthetists.

The question of the place of the general practitioner seems to be a controversial one at the present time. I feel that it is wholly a local matter, and each hospital must judge this situation for itself. Small hospitals, and I would say, in general, any hospital with one hundred beds or less, could and probably should be manned by general practitioners.

A workable plan for smaller hospitals is to have the heads of the various departments certified. Larger hospitals, I believe, should stimulate all members of the staff to be certified or to become members of their special societies or colleges. However, hospitals deciding to require certification would be wise in not making the rule retroactive. Senior members of the staff not certified should be kept in their present positions. Newly appointed men to the junior staff should be given a period of five years in which to qualify for certification. I believe that some members of certifying boards feel that, while it is desirable for staff men to be certified, its advisability will vary among hospitals, and should be decided by them.

Dr. Wingate Johnson, at the San Francisco session of the American Medical Association, read a splendid paper on the general practitioner, which has been widely read. At the mid-winter meeting of the House of Delegates of the American Medical Association, Dr. Edwin Askey of California presented a resolution recommending that general practitioners be given their rightful places on hospital staffs. General Hugh Morgan at a recent meeting of the Board of Regents of the American College of Physicians made a strong plea for the better general practitioners. He felt that some place should be found for these men in the College.

I believe firmly that there will always be a place in American medicine for the general practitioner. It is my further belief that that place will always be close to the hearts of the men in medicine and to the hearts of all of the American people. The old French proverb, "the irreplaceable man is yet to be," seems to fall down when one thinks of the general practitioner. No one can replace him.

Now still another controversial point in hospital organization is the appointment and election of members of the staff to the board of directors. The American College of Surgeons is opposed to the appointment of medical staff members to the board of directors.

The chief and perhaps the only reason is that favoritism will be shown those men so selected. I would like to go on record as being in total disagreement with this premise. Even if this were so in isolated cases, does this justify the indictment of all medical men? I think not. Does any one know an industry or a banking institution wherein one or more executives are not on the board of directors? Again I think not. The College recommends that a liaison committee be appointed by the staff to meet occasionally with the directors. This, in my opinion, is not enough. At almost every meeting of boards of directors, questions of medical administration and policy come up. With representatives immediately at hand, these questions can be decided at once. Good boards of directors hunger for the information and knowledge brought to them by members of the staff. Much good comes to the hospital, the board of directors and the staff by such close relationship.

And so, in the changing order we find or at least think we find it necessary to make changes in our plans for hospital organization. The basic conditions remain the same, the first purpose being to give the very best medical care to all the people, and the second purpose being vows of loyalty and industry by the members of medical staffs to the hospitals. It doesn't make any great difference whether these purposes are made possible by certified men or good general practitioners. Medicine and hospitals will make the necessary changes as indicated after careful consideration. They will be made slowly and carefully with the thought always before us that American medicine now leads the world in its care of the sick. We aim to keep it so.

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RADIATION SUPPLANTS REFRIGERATION

Sterilization of food by radiation for one millionth of a second is announced by two Brooklyn scientists, Dr. Arno Brasch and Dr. Wolfgang Huber. The food to be sterilized is subjected to bombardment with electrons which have from five hundred thousand to one million times the intensity of x-rays. After being subjected to this treatment, eggs, meat and fish keep perfectly for twelve days at a high temperature. Furthermore, milk, meat, blood plasma, and other materials already contaminated can be purified. The cost is so small that it will not affect prices.—*Good Health,* April, 1947.

Cardiac Complaints and Chronic Nonspecific Prostatitis

By Joseph A. Winter, M.D.
St. Joseph, Michigan

All of us have, at one time or another, seen patients whose complaints are apparently cardiac in origin; on examination, however, we cannot say with certainty that there is cardiac disease. The patient is convinced that he has some sort of heart disease and the physician must admit that there is justification for suspicion of cardiac dysfunction. And even if we cannot prove that actual heart disease exists, we feel that we must make mention of that possibility to the patient.

To the majority of patients, being told that there is a possibility, as yet unproved, of heart disease is practically the same as passing a death sentence on them. Auerback and Gliebe[1] in their masterful article entitled "Iatrogenic Heart Disease" have emphasized the dangers of carelessly imparting such information to the patient. These authors feel that the complaints which originally brought the patient to the doctor were, in the main, psychogenic.

This article is by no means an attempt to refute Auerback's astute observations. It is well known that emotional disturbances can be reflected in cardiac dysfunction. There are, moreover, numerous conditions within or below the diaphragm which can imitate cardiac disease. This article will attempt to show that there is yet another extracardiac condition hitherto unmentioned in the literature which must be considered in any case suggesting coronary disease.

Case Reports

Case 1.—L. S., a white male, aged forty-nine, a business executive, had a sudden attack of pain in the cardiac region while walking on the street. He was taken to a near-by hospital in an ambulance and admitted as the patient of another doctor. At the time of admission his blood pressure was 140/70, pulse 128 and irregular. (This irregularity was reported on the nurse's notes and was not noted on physical examination.) Physical examination was otherwise apparently negative. Blood count and urinalysis gave results within normal limits. X-ray of the lungs was negative. The electrocardiogram (Fig. 1) was described as normal, the consultant noting that "the cardiac problem is a clinical one." Nevertheless, it was necessary to administer oxygen to control the dyspnea, and morphine and dilaudid to control the pain.

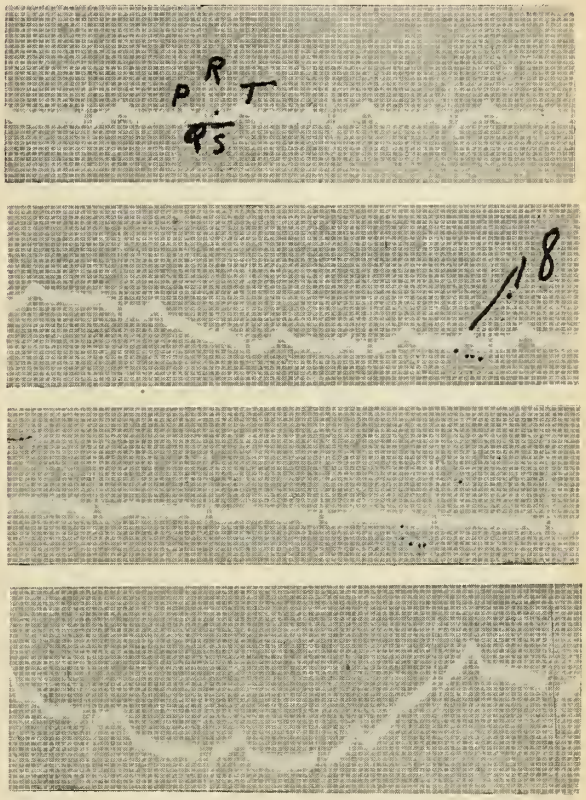

Fig. 1. Electrocardiogram for Case 1, described as normal.

In spite of the lack of proof of a lesion in the coronary arteries, the diagnosis on discharge was coronary disease, and the patient left the hospital firmly convinced that he was in imminent danger of sudden death.

Shortly after this (May, 1945) he was examined at Billings Hospital in Chicago. All the laboratory findings, including the electrocardiogram (Fig. 2), were normal. The patient was dismissed without a definite diagnosis having been made, although it was felt that he did not have a coronary thrombosis.

He was seen by me in December, 1945, at which time he intimated that he was convinced that there was something wrong with his heart. He complained of "gas crowding his heart," precordial pain and a sensation of suffocation. Further questioning elicited the complaints of nocturia and dribbling after urination. Examination of the prostate gland revealed that organ to be swollen and tender; with the third massage the secretion showed pus. Prostatic massages were given twice a week, and by March, 1946, he no longer had any complaints referable to his heart. The gaseous distension had also disappeared and his prostatic smear was normal. From the latest report he was still feeling quite well, enough so that he apparently needed no further medical attention.

Case 2.—G. P., a white male, aged forty-three, a business executive, began having attacks of pain in the chest in January, 1944. The pain was substernal in location and was referred to the epigastrium and to the left shoulder and arm. Pain was most apt to be noticed on lying down, although it was occasionally felt after exertion and, rarely, during cold weather. He was told that he had coronary heart disease and was advised to curtail his activities as much as possible. An electrocardiogram (Fig. 3), taken in October, 1945, was reported as showing left ventricular preponderance and "suggesting coronary insufficiency."

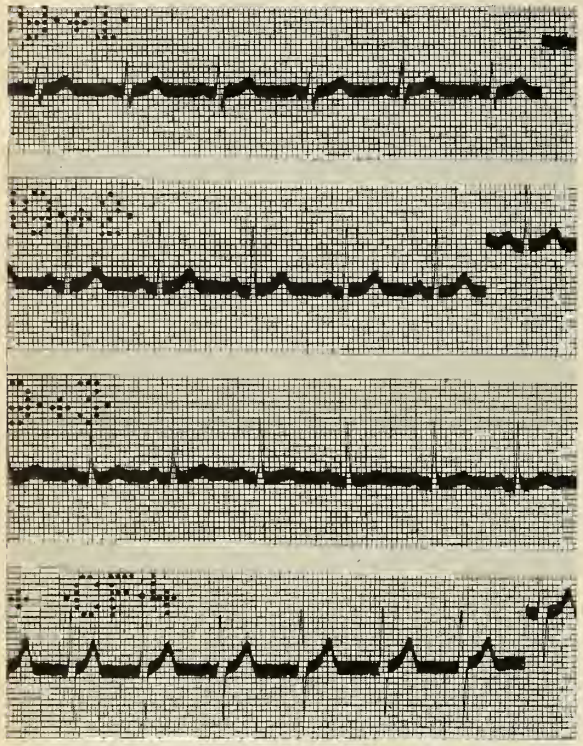

Fig. 2. Recheck electrocardiogram for Case 1, also described as normal.

In January, 1946, he consulted me because of gaseous distension, frequent belching and abdominal discomfort which, he said, "made his heart worse." He did not give a history of qualitative food dyscrasias which might suggest chronic gall-bladder disease. In the course of physical examination the only positive finding of note was that his prostate was swollen and tender; the secretion showed 2 plus pus, the cells being found singly and in clumps. Dilute hydrochloric acid was prescribed; this controlled the gassiness. On February 16 he discontinued the HCl and noticed that his heart skipped beats. This irregularity disappeared after resumption of the acid. By April, 1946, after having had prostatic massages once or twice weekly, he was feeling much better; he was able to spend a full day on a fishing trip without discomfort from his heart. He still notices, at infrequent intervals, pain in the chest when he first lies down. This is relieved promptly by belching.

Case 3.—F. E., a white male, aged thirty-four, factory worker. He complained of pain in the chest in the left midclavicular line at the level of the fourth rib; this pain was occasionally referred to the apex region or to the left shoulder. This pain had no relationship to exertion but was more noticeable after emotional disturbance. He had consulted several physicians for relief from this pain and had had several electrocardiograms taken, all of which were reported to be normal.

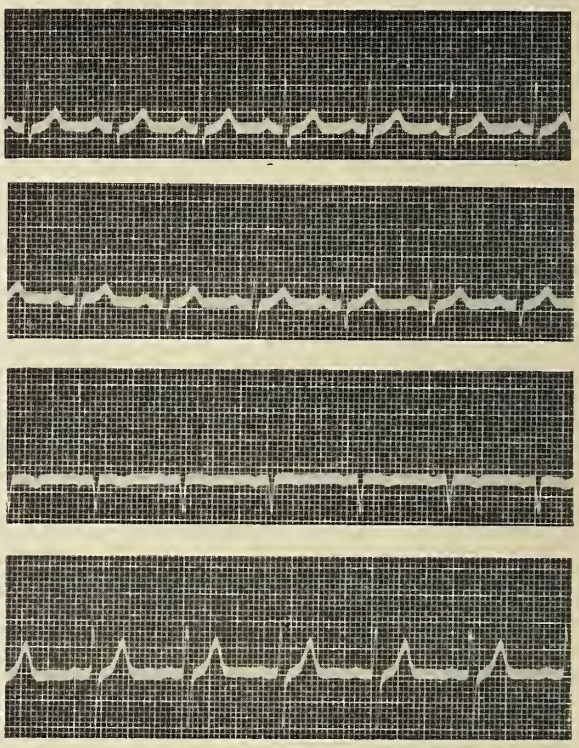

Fig. 3. Electrocardiogram for Case 2, reported as showing left ventricular preponderance and suggesting coronary insufficiency.

He first consulted me in March, 1946, with the above complaint. Further questioning elicited the history of occasional dysuria, occasional dribbling after urinating, impotentia eregendi and premature ejaculation. The prostate gland was found to be swollen and very tender, the secretion showing 4 plus pus. He was given prostatic massages once or twice weekly. At the present time he is completely free from all his previous complaints.

Case 4.—The author had an attack of severe substernal pain in July, 1944. This pain came on in the middle of the night and was accompanied by vomiting. An electrocardiogram taken the following day (Fig. 4) was interpreted by several of my colleagues as being definitely suspicious for coronary occlusion. The advice given me included, "wait and see," "take it easy," and "go to bed for six weeks." After several weeks of marked limitation of all unnecessary activity, further examinations were made, including the electrocardiographic re-

sponse to oxygen deficiency; the consultant told me that coronary disease could not be proved and to try to resume normal activity.

I still noticed substernal pain and pain in the left

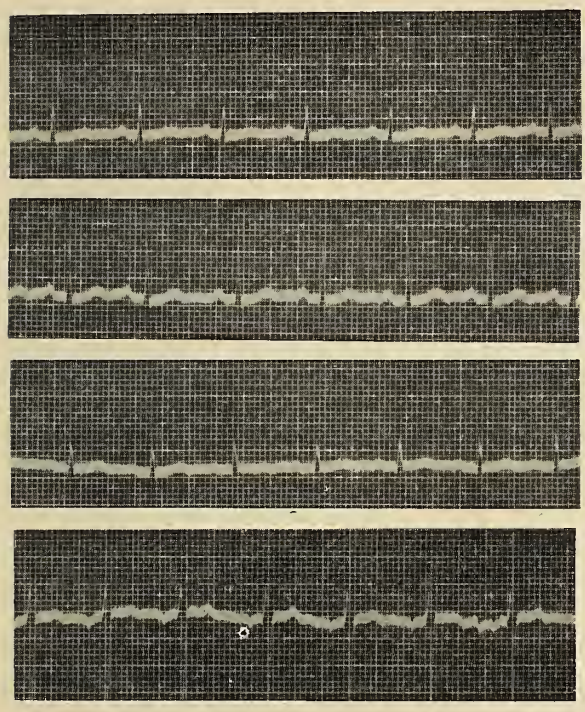

Fig. 4. Electrocardiogram for Case 4, interpreted as definitely suspicious for coronary occlusion.

shoulder on exertion or following overeating until January of this year. At that time symptoms of chronic nonspecific prostatitis, for which I had been treated in 1943, again made their appearance. After several massages the chest pain disappeared and has not returned in spite of a rather active life.

Discussion

It has long been known that extra-cardiac conditions play a role in coronary disease. Hiatal hernia of the diaphragm, cholecystitis, cholelithiasis, and chronic gastritis are frequent imitators of coronary insufficiency. Gilbert[3] believes that there is an actual decrease in coronary flow, and that this decrease is due to a reflex coming from the overdistension of the stomach. Gubner[4] points out that abdominal disease can cause definite changes in the electrocardiographic tracing and he quotes Gottesman et al., who mention that abdominal surgery often gives electrocardiographic changes. Clark[2] states that functional derangement of digestion and the irritable colon syndrome may also mimic or accent cardiovascular symptoms.

This author, in a previous paper[10] pointed out that various vague gastrointestinal complaints, suggestive but not typical of peptic ulcer and cholecystitis, are apparently caused by chronic nonspecific prostatitis. As can be seen from the above case reports, it is possible to go one step further and show that the gastrointestinal complaints, prostatic in origin, can in turn cause cardiac manifestations.

As far as can be determined, this is the first time that such relationship has been suggested. Harrison[5,6] has extensively reviewed the literature regarding chest pain; he makes no mention of prostatitis as a possible etiologic factor.

It may be admitted at this time that there is no law against a patient having more than one disease at a time. It is possible that these patients reported may have had coronary disease and gallbladder disease coexisting with the prostatitis. Moreover, some of these patients may in the future have an acute coronary occlusion. Nevertheless, in all these cases the greatest relief from chest pain was experienced only after the prostatitis had been brought under control.

It is interesting to speculate on the mechanism of this relationship between prostatitis and chest pain suggestive of coronary heart disease. Several different explanations might be made:

1. Prostatitis has been shown to be responsible for some cases of gaseous distension and other vague intestinal dysfunction. Through the so-called viscero-cardiac reflex, the heart may in turn be affected.

2. The author has observed in several cases that patients with chronic nonspecific prostatitis will have symptoms of the male climacteric and that these symptoms will subside after treatment of the prostate, without the necessity of administering testosterone.* If we may postulate a testosterone deficiency as a result of prostatitis, it may be that massage of the prostate gland has the same effect as administering testosterone. It is well known that testosterone is effective in the treatment of angina pectoris; Waldman[9] has reviewed the cases of ten patients so treated and cites a complete list of references of other workers who have had similar experience.

In this connection we should mention the work of Raab[7] who believes that "angina upon effort is caused by the specific anoxiating effect of sudden suprarenal discharges upon the heart muscle whose

*This author has now in progress an investigation to determine if there is any actual testosterone deficiency as a result of prostatitis; work has not sufficiently advanced to draw any conclusions as yet.

oxygen supply is inadequate due to sclerosis of the coronary arteries and their inability to dilate adequately."

It might be that, in the presence of a testosterone deficiency, the threshold of irritability of the adrenal medulla is lowered, thus permitting the sudden suprarenal discharges which Raab mentions. This is a point which will bear more investigation.

3. Perhaps both of these mechanisms work together. The author has seen ten or twelve other patients with the combination of circumstances pointed out in the case reports cited; these other cases, however, are not so clear-cut and were therefore not reported. The majority of these patients have a mild degree of hypogonadism, as manifested by small genitalia, flabby musculature and a tendency toward the girdle type of obesity. In other words, a man with an innate testosterone deficiency may be more susceptible to cardiac complaints if he gets a prostatitis.

You will notice that no great effort has been made to differentiate between pseudocoronary disease and actual coronary disease, as related to prostatitis. For the purposes of this paper it is enough to point out that prostatitis is one cause of chest pain; whether the chest pain is that of actual coronary disease, whether it is a manifestation of a functional embarrassment of coronary circulation, or whether it is not connected with coronary function at all, cannot be decided at this time.

Moreover, when prostatitis is found coexisting with chest pain, that pain can often be ameliorated by proper treatment of the prostate. From the patient's standpoint this is most valuable; it is this pain in his chest which brings him to the doctor and from which he seeks relief, no matter what the diagnosis.

It is admittedly a wild flight of speculation to infer that prostatitis can actually cause coronary heart disease. Yet the possibility remains that prostatitis can cause a functional disorder of the coronary circulation, which if permitted to go on unchecked, can ultimately result in organic changes. The monumental work of Selye[8] shows that many of our degenerative diseases may be due to a breakdown of the hormonal adaptive mechanism. We should therefore not lose sight of the idea that prostatitis might give rise to an endocrinopathy and thereby affect the heart.

Ignoring the purely speculative aspects, we may still use this paper to point out a fact which cannot be too often emphasized: all pain in the chest is not coronary disease, and we do our patients a distinct disservice when we, without having first exhausted all possibilities in the differential diagnosis, intimate that coronary heart disease may be present. Chronic nonspecific prostatitis is one of these etiologic possibilities.

It should also be pointed out that this paper is not intended to prove irrefutably that there is a relationship between prostatitis and apparent coronary disease. It is hoped, rather, that this will suggest and stimulate further investigation of a possibility hitherto unmentioned.

Summary

Chronic nonspecific prostatitis, in addition to other extra-cardiac disorders, may give rise to symptoms suggestive of coronary disease.

Some speculations as to the possible mechanisms involved are suggested.

References

1. Auerback, A., and Gliebe, P. A.: Iatrogenic heart disease. J.A.M.A., 129:338, (Sept. 29) 1945.
2. Clark, W. E.: Gastro-intestinal conditions and cardiovascular disease. J.A.M.A., 128:352, (June 2) 1945.
3. Gilbert, N. C.: Importance of certain extracardiac conditions in coronary disease. Wis. M. J., 44:512, (May) 1945.
4. Gubner, R. S.: J.A.M.A., 124:122, (Jan. 8) 1944.
5. Harrison, T. R.: Clinical aspects of pain in the chest. Am. J. M. Sc., 207:561, (May) 1944.
6. Harrison, T. R.: Some puzzling aspects of pain in the chest. J.A.M.A., 120:519, (Oct. 17) 1942.
7. Raab, W.: Abnormal suprarenal discharges in angina pectoris and their control by x-ray therapy. J. Clin. Endocrinol., 1:977, (Dec.) 1941.
8. Selye, H.: The general adaptation syndrome and the diseases of adaptation. J. Clin. Endocrinol., 6:117, (Feb.) 1946.
9. Waldman, S.: The treatment of angina pectoris with testosterone proprionate. J. Clin. Endocrinol., 5:305, (Sept.) 1945.
10. Winter, J. A.: Chronic non-specific prostatitis and gastro-intestinal complaints. J. Michigan M. Soc., 45:210, (Feb.) 1946.

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WASTE OF WAR

"We have been told that the little sum of 300 billion dollars was expended by this country to fight the recent war, a small matter of seventy-five billion a year, or six and one-half billion a month, or only 650 million in thirty days. Dear Doctor, for the small cost of thirty days of warfare a million-dollar hospital building completely equipped could have been placed in every county of the United States. Think of what could have been done with the proportionate expenditures that were made during the other forty-seven months of wartime waste."—H. B. Jenkins, M.D., *The Journal of the Medical Association of Georgia,* July, 1946.

Treatment of Hyperthyroidism

Present Status

By George Crile, Jr., M.D.
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THIOURACIL PROVED too toxic for standard use as either a definitive treatment for hyperthyroidism or a means of preparing patients for operation. Its value was confined to cases of desperate surgical risk or to cases of recurrent hyperthyroidism when considerations of surgical mortality or morbidity outweighed the dangers of toxicity.

The disappointment felt by the profession in thiouracil and thiobarbital has prejudiced many physicians against the antithyroid drugs and has led them to regard with suspicion the more recently developed thiouracil derivatives. This suspicion is poorly founded because propyl thiouracil, developed by Astwood[1], has proved to have only a small fraction of the toxicity of the older drugs and, when given in adequate doses, is equally effective. Collected figures indicate that at least 500 patients have been treated with propyl thiouracil without a fatality and that there has been only one case of agranulocytosis, the etiology of which is in dispute.

One hundred and ten patients have been treated with propyl thiouracil at Cleveland Clinic in the past eight months, and in only one case has its use been discontinued because of possible toxicity. The patient from whom the drug was withdrawn developed leukopenia with 4,000 leukocytes but only 28 per cent granulocytes. Agranulocytosis has not occurred in these patients; there have been no skin rashes, no fevers, and no unpleasant side effects.

Sufficient time has not elapsed to evaluate the end results of therapy with the antithyroid drugs. When thiouracil was used, nearly 20 per cent of the patients developed symptoms of toxicity, hence there was a tendency to discontinue the drug as soon as the metabolism reached normal.

Presented at the eighty-first annual meeting of the Michigan State Medical Society, Detroit, Michigan, September 25, 1946.

This practice often led to a prompt recurrence of hyperthyroidism and to the attitude that the drug was incapable of producing a high percentage of lasting remissions. The same situation must have arisen in the early days of thyroid surgery when the fear of technical complications prevented the surgeons from removing an adequate amount of thyroid tissue.

We now have reason to believe that the incidence of lasting remissions following withdrawal of thiouracil or propyl thiouracil is directly proportional to the length of time during which the hyperthyroidism is kept in complete control. Studies by Astwood[1] indicate that long-standing remissions or possibly permanent cures may be expected in from 70 to 80 per cent of the cases. In our experience, including a number of early cases in which it is now admitted that the drug was withdrawn too soon, incidence of long-standing remissions has been slightly over 50 per cent.

Propyl thiouracil has proved to have so little toxicity that we have abandoned the practice of repeatedly rechecking the leukocyte count. The patient is warned of the possibility of untoward reactions, and he is instructed to report a sore throat, fever, malaise, or skin rash. He is ambulatory throughout and usually is able to continue to work. The basal metabolic rate is determined once a month for the first few months, and the dosage of the drug is varied accordingly. In most instances 150 to 200 mg. daily is required to control the hyperthyroidism, and 50 to 75 mg. to maintain the remission. It is important to maintain the basal metabolic rate at a level lower than +10 per cent.

It has been suggested that remissions induced by the antithyroid drugs are not so complete as those following thyroidectomy, and that certain residual symptoms persist. In our experience this has not been true. Analysis of any large group of patients subjected to thyroidectomy for hyperthyroidism will show a certain number in which complaints of nervousness, weakness, and palpitation persist. A few of these may represent errors in diagnosis; others probably had a coexistent neuro-circulatory asthenia, functional disorder, or residual damage from the hyperthyroidism. In any case, no group of patients whose hyperthyroidism has been successfully controlled by thyroidectomy will all report 100 per cent relief from symptoms, nor will all patients treated by thiouracil report 100 per cent

relief. Residual symptoms do not appear to be any more common in one group than in the other.

It has also been suggested that carcinoma of the thyroid may occur in response to treatment with the antithyroid drugs. This suggestion finds little support in the experimental work of Purves[2] et al, in New Zealand, whose studies indicate that in mice it requires a year of continuous treatment with antithyroid drugs to produce even an adenoma. A year, to a mouse, is perhaps the physiologic equivalent of many years in a man, and to date there has been no clinical evidence of the development of tumors in patients treated with the antithyroid drugs. In the majority of patients treated with propyl thiouracil the glands become smaller and softer, and adenomatous changes have not been observed.

Carcinoma of the thyroid is rarely seen in the presence of frank hyperthyroidism. In a series of 249 carcinomas of the thyroid treated at Cleveland Clinic, no cases of indisputable hyperthyroidism were observed. Extensive metastasis may simulate hyperthyroidism, and occasionally the basal metabolic rate may be a little elevated, but this is rare. The average basal metabolic rate of the group was 0.3 per cent.

There is a rare tumor of the thyroid classified by Dr. Allen Graham as a "carcinoma not arising in an adenoma" which is in reality a type of carcinoid. The tumors in this group have always been very small and were discovered accidentally in a thyroid gland removed for some other reason. None of these patients have had recurrence of the tumor. No doubt one of these "carcinoids" will be removed from a patient who has had an antithyroid drug, and controversy will arise as to whether the drug was responsible for its development. In general, fear of carcinoma in patients with frank hyperthyroidism is poorly founded.

One of the most important factors in determining whether the definitive treatment of hyperthyroidism should be by thyroidectomy or by the antithyroid drugs is the consideration of the basic physiology involved in a thyroid remission. Is there any reason to believe that the remission induced by operation is any more complete, any more lasting, or any more physiologic than following the use of propyl thiouracil?

When hyperthyroidism arises as the result of functional activity in a long-standing adenoma, it is not surprising that removal of the benign tumor responsible for the hyperthyroidism is followed by a low incidence of recurrent hyperthyroidism. The factors responsible for the development of the original adenoma may no longer be in operation, and if excision has been complete there is no reason for the hyperthyroidism to recur.

In diffuse goiter with hyperthyroidism, however, the entire gland is stimulated to hypertrophy, hyperplasia, and hyperfunction by causes which are not fully understood. It seems unlikely that the primary seat of the disease is in the thyroid gland itself. Moreover, subtotal thyroidectomy does nothing to eliminate the factors that originally stimulated the hyperplasia and hyperfunction. Hence, the surprising clinical feature is not that hyperthyroidism occasionally recurs but rather that the disease does not "always" recur.

The incidence of persistent hyperthyroidism following operation is easy to determine. Persistence of hyperthyroidism usually represents a technical error resulting from insufficient removal of thyroid tissue. This accident is rare and occurs only in a fraction of 1 per cent of all cases of hyperthyroidism if thyroidectomy has been well done. The true incidence of recurrent hyperthyroidism, on the other hand, is most difficult to determine and will depend almost entirely on the length of the followup. Although the greatest incidence of recurrent hyperthyroidism is in the first five years following thyroidectomy, the disease may recur at any time. A patient may remain well for twenty years only to develop late in life recurrent hyperthyroidism. It is estimated that the over-all incidence of persistent and recurrent hyperthyroidism after an adequate thyroidectomy does not exceed 5 per cent.

If these figures are further broken down to separate the diffuse goiters with hyperthyroidism (true Graves' disease) from the nodular goiters with hyperthyroidism, it is apparent that the majority of patients with recurrent hyperthyroidism are those who had diffuse hyperplastic goiters. It is the true exophthalmic goiter that has the highest tendency to cause recurrent hyperthyroidism after thyroidectomy.

Total thyroidectomies are seldom performed in the treatment of hyperthyroidism because of the prohibitive incidence of parathyroid tetany. Studies conducted in relation to total thyroidectomy for heart disease and experiments on animals have shown that unless every vestige of thyroid tissue is removed, regeneration of the thyroid promptly restores its function to normal. This

regeneration occurs as a compensatory hypertrophy and hyperplasia stimulated by the pituitary gland in response to a deficiency in circulating thyroid hormone. Since (1) the thyroid remnants are capable of regeneration, (2) a considerable portion of the thyroid remains following subtotal thyroidectomy, and (3) the true causes of hypertrophy, hyperplasia, and hyperfunction of the thyroid in hyperthyroidism are not removed by thyroidectomy, why is it that the remnants of the thyroid do not always enlarge and cause recurrence of the disease?

On the basis of present knowledge there is no answer to this question unless it is assumed that subtotal thyroidectomy breaks a link in a "vicious circle" of nervous and/or endocrine disorders. It is possible that thyroidectomy, by accomplishing a reduction to or below normal in the output of thyroid hormone, secondarily causes a subsidence of the factors that incite the thyroid gland to hyperfunction.

In any case it is clear that thyroidectomy for diffuse goiter with hyperthyroidism is empiric in approach, unpredictable in outcome, and unphysiologic in principle, but from a clinical standpoint is safe, simple, and satisfactory. An unphysiologic procedure is proved empirically to be a sound clinical treatment. Is the treatment of hyperthyroidism with propyl thiouracil more predictable in its end results or more physiologic than removal of the gland?

So far as has been determined, the effect of propyl thiouracil is primarily on the thyroid gland. By blocking formation of active thyroid hormone, propyl thiouracil accomplishes a physiologic instead of an anatomic subtotal thyroidectomy. If given in large enough doses over a long enough period of time, it might often produce the physiologic equivalent of a total thyroidectomy.

The same questions can be asked about the results obtained with propyl thiouracil as were asked about those following thyroidectomy. Why does not the hyperthyroidism invariably recur after withdrawal of the drug? Thiouracil, so far as is known, has no more effect than thyroidectomy on the master system that first stimulated the thyroid gland. Nevertheless, following thiouracil therapy, prolonged remissions have been obtained in at least 50 per cent of the patients. How long these remissions will last is uncertain. It would appear that physiologic thyroidectomy by thiouracil therapy breaks the "vicious circle" just as anatomic thyroidectomy does. When a remission is obtained with thiouracil the end results are unpredictable, just as they are following thyroidectomy. Recurrence of hyperthyroidism, however, appears to be more common after a course of thiouracil than following an adequate thyroidectomy.

When severe postoperative hypothyroidism or myxedema occurs, the subsequent development of recurrent hyperthyroidism is extremely rare. I do not believe that this is because there is insufficient thyroid tissue left to regenerate and cause a recurrence if the stimulating mechanism were in operation. It seems more reasonable to suppose that in these cases the "vicious circle" is more completely broken by induction of severe hypothyroidism.

Long-standing remissions following thiouracil therapy were few because the toxicity of the drug was too high to permit its continued use. Since propyl thiouracil is less toxic, and large doses can be given safely over a long period of time to produce a complete remission and to maintain it indefinitely, the "vicious circle" may be so completely interrupted that recurrences will be rare.

Subtotal thyroidectomy and treatment with the antithyroid drugs accomplish essentially the same end by different means. Both methods of treatment depend upon inducing a temporary remission of the hyperthyroidism. During this remission the "vicious circle" of the pathologic physiology is broken, and in those patients who are to remain well, the abnormal stimulation of the thyroid is abolished.

Any drug which is as safe as a surgical operation and which can accomplish the same ends without incurring discomfort and occasional morbidity, to say nothing of loss of time from work and the expense of hospitalization, is a better therapeutic measure than surgery. Propyl thiouracil fulfills these qualifications and does not have the disadvantage of marked toxicity. A drug has been found which can safely and apparently in many cases completely break the "vicious circle" of thyroid stimulation and produce a lasting remission after its withdrawal.

It is now possible to replace anatomic thyroidectomy by physiologic thyroidectomy, and it is hoped that remissions so induced will be as permanent and as satisfactory as are obtained by thyroidectomy. If they do not prove so, it will be necessary either to give small maintenance doses of propyl thiouracil for an indefinite period of time or at

some subsequent date, with the hyperthyroidism completely controlled, to resort to thyroidectomy. For the present, at least, there seem to be no indications for thyroidectomy in diffuse goiter with hyperthyroidism.

In adenomatous goiter the situation is somewhat different because of the presence of one or more tumors in the thyroid. These are of cosmetic importance, tend to enlarge, tend to produce symptoms of pressure, and are of possible significance in respect to malignancy. Because tumors of any organ are potentially troublesome, and because the risk of operation is slight unless the hyperthyroidism is severe, it is preferable in the majority of cases to prepare the patient with iodine and remove the goiter. If the hyperthyroidism is severe, if the patient is over fifty years of age, or if there be cardiac complications or other factors to increase the risk of operation, the metabolism is reduced to normal by propyl thiouracil before thyroidectomy is undertaken.

If the propyl thiouracil is discontinued two or three weeks before thyroidectomy and iodine is given, as suggested by Lahey[3], the technical difficulties of thyroidectomy are not significantly increased.

In the aged or in those in whom life expectancy is short, even adenomatous goiter can be treated definitively with propyl thiouracil with good results. In view of the fact that hyperthyroidism can be controlled with safety in patients not intolerant of the antithyroid drugs, it does not seem reasonable to assume the needless risk of operation upon a patient with severe or complicated hyperthyroidism without first completely controlling all signs of toxicity and reducing the basal metabolic rate to normal.

Summary

1. Thiouracil proved too toxic for general use in the treatment of hyperthyroidism.

2. Propyl thiouracil has had an adequate trial for evaluation of its toxicity and efficacy, and it has proved both safe and effective.

3. The symptoms of hyperthyroidism are as effectively controlled by propyl thiouracil as by thyroidectomy.

4. The final evaluation of the incidence and permanency of remissions following withdrawal of antithyroid drugs cannot be made at this time. If the hyperthyroidism is completely controlled by giving the antithyroid drugs for periods of from six months to a year, it is thought that at least 75 per cent of the patients will obtain lasting remissions.

5. As yet there is no evidence that treatment of hyperthyroidism with antithyroid drugs increases the danger of carcinoma of the thyroid.

6. Propyl thiouracil accomplishes a physiologic rather than an anatomic thyroidectomy, and the mechanism by which it produces a remission is comparable in many respects to that of thyroidectomy.

7. At the present time it appears that propyl thiouracil is the treatment of choice for diffuse goiter with hyperthyroidism, and that thyroidectomy is seldom indicated.

8. Because adenomatous goiters are tumors of the thyroid and because tumors are potentially dangerous, thyroidectomy is still the treatment of choice for most nodular goiters of significant size.

9. The majority of patients with nodular goiters and mild hyperthyroidism are best prepared for operation with iodine.

10. Propyl thiouracil is used in the preoperative preparation of patients with severe hyperthyroidism, of patients over fifty years of age, and of patients with complications increasing the risk of operation.

11. Nodular goiter with hyperthyroidism occurring in aging patients or in patients with short life expectancy can be successfully and definitively treated with propyl thiouracil.

12. The toxicity of propyl thiouracil is so low that it is not necessary to make repeated leukocyte counts or to observe the patients more than once a month.

References

1. Astwood, E. B., and Vanderlan, W. P.: Thiouracil derivatives of greater activity for the treatment of hyperthyroidism. J. Clin. Endocrinol., 5:424-430, (Dec.) 1945.
2. Griesbach, W. E.; Kennedy, T. H., and Purves, H. D.: Studies on experimental goitre; effect of goitrogenic diet on hypophysectomized rats. Brit. J. Exper. Path., 22:249-254, (Oct.) 1941.
3. Lahey, F. H.; Bartels, E. C.; Warren, S., and Meissner, W. A.: Thiouracil—use in the preoperative treatment of severe hyperthyroidism. Surg., Gynec., and Obst., 81:425-439, (Oct.) 1945.

MSMS

Little Joe Genius says—

I see where state medical society dues are high in some states. One state pays $111, three pay $50, one pays $40, two pay $35, one $33, two $30, seven $25, and four pay $20. But these are mostly pikers when compared with any well-organized union.

Paralysis of the Larynx

By Louis H. Clerf, M.D.
Philadelphia, Pennsylvania

Paralysis of a vocal cord rarely is caused by disease of the larynx. The causes must be found within the thoracic cage and mediastinum, neck or cranial cavity. Paralysis usually is secondary to a lesion of a peripheral nerve. Disease of the central nervous system is responsible for about 10 per cent of all cases. Paralysis of a vocal cord, therefore, more often is a problem for the internist and general practitioner than for the laryngologist. It should not be considered as a distinct clinical entity but as a symptom or a local manifestation of disease elsewhere.

Although agreement is not unanimous on the innervation of the larynx, the views expressed by Onodi are generally accepted, namely, that all the muscles of the larynx except the cricothyroideus are innervated unilaterally by the corresponding recurrent laryngeal nerve. The arytenoideus, an unpaired midline muscle, is supplied by both right and left recurrent nerves. The cricothyroideus is supplied by the corresponding external subdivision of the superior laryngeal nerve.

The terminology applied to the position of the paralyzed vocal cord also appears complicated. References are made to median, paramedian, mid, adductor, abductor, phonatory, intermediate and cadaveric positions. Obviously there are but three positions that the vocal cord can assume, namely, (1) in the midline or in a position of adduction, (2) in a position of abduction, and (3) in a position midway between these, that is, between abduction and adduction. There usually is some relaxation of the cord, although often this may be so slight that there is no interference with the speaking voice. In observing cases of paralysis, particularly unilateral, one must take into account the bilateral innervation of the arytenoideus muscle, which may produce tilting of the paralyzed arytenoid towards the midline, suggesting that there is adductor movement. In addition, consideration must be given the cricothyroideus which, although primarily a tensor muscle of the vocal cord, also exerts some adductor action. This is observed in bilateral paralysis of the larynx.

Paralyses commonly are classified as central and peripheral in origin. Among the chief causes of central paralysis are progressive bulbar paralysis, tabes, syphilitic arteritis, syringomyelia, disseminated sclerosis, vascular accidents, trauma involving the base of the skull, tumors and abscesses. Bilateral paralysis of the larynx of central origin would be more readily recognized because of the occurrence of dyspnea and hoarseness. Unilateral paralysis probably often is overlooked because of its association with other more obvious paralyses.

Peripheral lesions may involve the vagus nerve at the jugular foramen, the superior laryngeal branch in the neck, and the recurrent or inferior laryngeal branch in the neck or mediastinum. These may be conveniently subdivided according to the cause:

Mechanical
Traumatic
Neoplastic
Inflammatory
Idiopathic

Among the common mechanical causes which produce pressure on the recurrent nerve are aneurysm of the aorta and cardiac enlargement.

Paralysis following traumatic causes is one of the most frequently observed groups. This may be surgical or nonsurgical. Of the surgical, thyroidectomy is the most common, although paralysis has been observed occasionally following diverticulectomy. While injury to the recurrent nerve during thyroidectomy is variously explained, it occurs during the course of the operation and is the result either of incising, pinching, clamping, or including the nerve in a ligature or tearing it loose at the point where it enters the larynx. Not infrequently the paralysis occurs bilaterally. In a group of sixty-one cases of paralysis following thyroidectomy observed in this clinic, thirty-three were bilateral and twenty-one of these required tracheotomy for dyspnea.

In unilateral paralysis occurring during the course of thyroidectomy, there may be no voice disturbances and there commonly is no dyspnea. The paralysis frequently is not discovered unless the larynx is examined. In bilateral paralysis the

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common symptoms are dyspnea and stridor which may occur while the patient still is on the operating table. Voice disturbances also are common early, but within a few days the conversational voice may be normal although the patient exhibits dyspnea when talking.

The sound of the voice is not a good criterion for determining the presence or absence of paralysis of the larynx. Loss of tension of the vocal cord rarely is observed in this group, and if the larynx is observed only during phonation, it exhibits a normal appearance.

Other traumatic causes include gunshot and stab wounds and massive trauma to the neck. These often are associated with direct injury to the larynx itself so that one must differentiate between cicatricial changes, disturbances of the cricoarytenoid joint, and paralysis.

Among the neoplastic causes, carcinoma of the esophagus has been found the most frequent, due to the growth infiltrating the esophageal wall and involving one or both recurrent nerves. Carcinoma of the thyroid gland and trachea and metastasis to mediastinal lymph nodes from carcinoma of the bronchus are not infrequent causes. We have observed six cases of paralysis of the larynx occurring as the initial symptom of recurrence in operated cases of mammary gland cancer. This proved to be due to metastasis to mediastinal lymph nodes.

Unfortunately, practically all of the cases of paralysis secondary to malignant tumors are not amenable to any plan of therapy once the diagnosis has been made.

Tumors of the thyroid gland, unless malignant, rarely are associated with paralysis of the larynx irrespective of their size. A safe working rule is to assume that any tumor of the thyroid gland associated with paralysis of a vocal cord probably is malignant.

Among the inflammatory group are paralysis due to toxic neuritis, particularly lead poisoning, also occurring during the course of acute infections and probably of viral origin. It is difficult to establish the cause in these, and some must be classified as idiopathic. Six cases of unilateral paralysis occurring in young adults, in association with what was described as a grippe infection, have been observed. There was adduction of the vocal cord with loss of tension and marked hoarseness. All of these cases ultimately made a complete recovery within five or six months.

The diagnosis of paralysis of the larynx usually can be made without difficulty. Whenever possible, the larynx should be examined by mirror laryngoscopy, for the use of a direct laryngoscope may interfere with determining the degree of motility of a vocal cord. Observing the vocal cords during inspiration and phonation will give one sufficient information to determine if there is present a unilateral or bilateral paralysis. If there is question, the cords should be observed during cough. This latter aid is of value in so-called functional paralysis.

Determination of the cause of the paralysis is more difficult. It is important to secure a complete history, for this often will give a clue to the etiology. Routine roentgen studies of the chest should be carried out. In addition, serological tests of the blood may be made. Functional study of the swallowing function is indicated if there are symptoms referable to the esophagus. Patients with paralysis of the larynx frequently have dysphagia due to interference with the protective function of the larynx. A neurological examination, direct laryngoscopy, bronchoscopy and esophagoscopy may be required. In spite of complete studies a certain number of cases of paralysis, approximately 10 to 12 per cent, will remain unsolved so far as the etiology is concerned. These have been listed as idiopathic cases. Probably some are of toxic origin. Others may be the result of pinching of the nerve by thickened pleura along the mediastinal aspect of the upper lobe of the lung, particularly the left.

Treatment presents a difficult problem. There is no known medical treatment which will restore function. As a rule, the cause cannot be removed. In the unilateral there is no dyspnea, and the only disability is huskiness or hoarseness. In the bilateral case, dyspnea occurs only if the tension of the cords is good. Loss of tension causes marked hoarseness and interferes with cough but provides an ample airway. Tracheotomy always is indicated in the presence of dyspnea.

The fate of the paralyzed cord is dependent on the cause. In paralysis following thyroidectomy or diverticulectomy, or occurring during an acute infection, there may be restoration of function in four to six months. One rarely sees function return after six months. One therefore should defer any plan of surgical treatment, except tracheotomy, until at least six months after the occurrence of the paralysis.

Treatment.—Attemps at anastomosis of the recurrent nerve have been carried out but the results

(Continued on Page 484)

Determination of Unmet Need for Medical Attention Among Michigan Farm Families

By Charles R. Hoffer and Edgar A. Schuler
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In co-operation with
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For a long time there has been general recognition of the fact that many rural people need more medical attention than they actually receive. Low income of many farm families, distance to a doctor, cost of medical and hospital facilities, and unwillingness of some persons to go to a doctor, even when one is near at hand, are some of the circumstances that contribute to this problem.

Beyond these broad statements there is a lack of reasonably accurate information on what proportion of the rural population actually has insufficient medical care, or the extent to which the unmet need varies among different localities. In the absence of this information, doctors, hospital administrators, and public health workers have to depend largely on their own estimates of the medical needs of the population in either rural or urban communities. Naturally the available mortality and morbidity data are useful to some extent, but they are accurate only when medical care is employed. They do not serve, nor are they intended to serve, as measures of unmet need for medical care. It seems obvious that more exact data to show the extent of need for medical attention would aid the doctor and the health worker to predict with greater accuracy the probable or potential demands for their services. Also information of this kind might increase the awareness of other leaders in a given community regarding its own health problems.

The present article describes first a method and second an experiment to determine the validity of that method, designed to measure the need for medical attention among farm people. It should be pointed out at the beginning that the proposal is not intended to be a substitute for a physical examination or to provide a diagnosis of particular ailments. Diagnosis is a function of the physician. The function of the method here presented is to measure for a given community or population group the relative frequency of need for medical care.

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Grateful acknowledgment is made to the Michigan Rural Rehabilitation Corporation which helped to finance the cost of certain tabulations used in this article.

Characteristics of Medical Needs Schedule

It was assumed that a method to measure medical needs, both in terms of their existence and the extent to which they are met or unmet, would have to be relatively simple and inexpensive if it were to be used with large numbers of families. Admittedly, the ideal would be physical examination of the population by qualified physicians. The latter procedure, however, is expensive, and at present most physicians are too busy to have time for such exploratory work. Consequently, an attempt was made to devise a method that would make it possible for a lay interviewer to obtain the desired type of information. The development of this method will be described in the next section. At this point its essential elements may be described as follows:

1. It is a list of questions on the presence or absence of certain symptoms, ailments, or conditions, based on the questions ordinarily used by doctors in taking a patient's medical history.

2. The questions are of sufficient medical importance that if any one is reported positive for a family member, that person is regarded as having a need for medical attention, at least to the extent of consulting a physician and perhaps obtaining a thorough examination.

3. These questions are stated in a way that an informant possessing an ordinary vocabulary can readily understand them.

4. Questions about symptoms are worded so that a person without medical training, if properly instructed and supervised, can obtain the desired information. A set of instructions has been developed to help standardize the procedure.

5. The schedule is planned so that one member of the family, preferably the housewife, is called upon to give the information about herself and other members of her family.†

6. The answers to the questions are recorded by symbols to show whether a person reporting a positive symptom has seen a medical doctor about it,

†Comparison of results of interviews with wives reporting from 192 families, with those of husbands reporting for 102 families, showed no outstanding differences. Likewise, results secured by a man interviewer with 22 families were similar to those reported by a woman interviewer of 31 families in the same county.

TABLE I. PERCENTAGE OF INDIVIDUALS NEEDING AND NOT NEEDING MEDICAL CARE

As determined by Medical Needs Schedule and confirmed or not confirmed by medical examination, based on a sample of 153 individuals, Michigan, 1946.

	Per Cent
Schedule data **confirmed** by medical examinations:	80.0
Persons needing medical attention	40.0
Persons not needing medical attention	40.0
Schedule data **not confirmed** by medical examination:	20.0
Persons needing medical attention according to Medical Needs Schedule but not according to medical examinations	6.0
Persons not needing medical care according to Medical Needs Schedule but needing medical care according to medical examinations	14.0

has seen a non-medical practitioner, or has used home remedies only. Thus it is possible to appraise the proportion of persons in a given group having unmet medical needs.

Development of Medical Needs Schedule

In the summer of 1944 the Bureau of Agricultural Economics, in the United States Department of Agriculture, obtained the assistance of physicians attached to the United States Department of Agriculture in the development of a series of questions designed as an exploratory schedule to measure health conditions and health care needs of farm families. These questions constituted one section of a lengthy standard and level of living schedule which included such phases as food, clothing, housing, transportation, and education.

This exploratory schedule was tested with a small number of families in a rural county in New Jersey. The schedule was then revised in consultation with the co-operating physicians and again tried out with rural families in several states: New York, Pennsylvania, Virginia, South Carolina, Tennessee and Alabama. Over forty symptom questions were included in the revision of the schedule for the second field test. Data were obtained on about 200 persons in 41 families. These data were then carefully analyzed and further revisions were made in the list of questions. The total number was reduced to twenty-two, and at the same time the formulations which appeared to cause disagreement in the evaluation of co-operating physicians were re-stated to guarantee more nearly a medically serious condition. For example, the question on headaches was changed from the simple statement, "headaches" to "persistent headaches." A number of genito-urinary symptoms which tended to cause embarrassment to the lay interviewer were dropped from the schedule. These included such items as "painful urination," "bloody stools" and "constipation." It is clear, therefore, that the final list of symptoms in the Medical Needs Schedule cannot be regarded as covering all the significant points which would be included in a physician's questioning of a patient for his clinical history, but the final formulations of the questions retained were regarded by the co-operating physicians as having unquestionable medical significance.

This schedule was then used in a field test in Warren County, North Carolina. A lay interviewer secured the information from about forty families, and a United States Public Health officer put the same questions to the same informants a few days later.[1] The reports showed sufficiently close agreement between the results of the lay interviewer and the physician to warrant further experimentation with the approach.

The Michigan Experiment

The Medical Needs Schedule was included in a study of the medical needs for farm families in connection with a project sponsored by the Michigan Agricultural Experiment Station during the spring and summer of 1946. A total of 306 families, selected according to scientific sampling procedures, were interviewed in three counties, namely, Shiawassee, Kent and Cheboygan. The counties themselves were also carefully chosen with due regard to such factors as density of population, number of persons per physician, purchasing power, and other factors, so that the counties would represent as nearly as possible typical areas of the state. The data of this study are being used in a bulletin to be published by the Michigan Agricultural Experiment Station.

Both because this study involved such a large number of families, and because precise evaluation of this approach was lacking, it seemed wise to validate the data regarding need for medical attention. This was accomplished by having a sample of the families who were interviewed receive a medical examination so the findings of the two approaches could be compared. Such a procedure, it was thought, might provide a crucial test of the method. Before the Michigan Study was started, however, decision was made to test five additional symptoms, namely, lumps or discolored patches on the skin, asthma, repeated or persistent bleeding of the gums, sore mouth due to bridges or plates,

and inability to chew food on account of sore or missing teeth. Thus the total number of symptoms included in the form of the Medical Needs Schedule used in the Michigan Study was twenty-seven.

TABLE II. DISTRIBUTION OF 124 POSITIVE SYMPTOMS REPORTED BY MEDICAL NEEDS SCHEDULE AND CONFIRMED OR NOT CONFIRMED BY MEDICAL EXAMINATION

Involving 82 individuals in a sample of 153 persons who were examined, Michigan, 1946.

Symptom	Symptom Confirmed	Symptom Neither Confirmed Nor Denied	Symptom Not Confirmed	Total
Persistent pains in the joints	7	0	8	15
Toothache	4	6	4	14
Poor vision: for distant or close work, such as reading	7	4	1	12
Repeated or persistent backache	7	1	2	10
Persistent skin rashes or itching of skin: breaking out (one week or more)	3	2	4	9
"Rupture", hernia, or wearing of truss	6	1	1	8
Repeated nosebleeds not due to blow or injury	5	2	0	7
Asthma	6	0	0	6
Persistent headaches	3	2	1	6
Severe shortness of breath: after doing light work	4	0	2	6
Accidental injuries: broken bones, head or severe injuries, accidental poisoning, snake bites, etc.	4	0	1	5
Continued loss of appetite	3	1	1	5
Unable to chew food: "sore teeth" or teeth missing	3	0	1	4
Unexplained tiredness: regularly	1	3	0	4
Sore mouth: due to plates or bridges	1	2	0	3
Lumps or discolored patches on skin	0	1	1	2
Running ear or ears: watery, bloody pus	2	0	0	2
Fainting spells; stuttering; stammering; nervous breakdown; fits; convulsions	0	0	1	1
Open or running sores that do not heal: leg or foot ulcers, others	0	1	0	1
Persistent cough (except cold in chest)	1	0	0	1
Persistent pain in chest	1	0	0	1
Repeated or persistent swelling of ankles: (two weeks or more)	1	0	0	1
Repeated or prolonged pains in the stomach or anywhere in the abdomen	0	0	1	1
Coughing or spitting blood	0	0	0	0
Repeated or frequent bleeding of gums	0	0	0	0
Repeated vomiting: (several days or more)	0	0	0	0
Unexplained loss of weight: persons over 18: 10 pounds or more in past 6 months; persons under 18: any unexplained loss of weight	0	0	0	0
Totals	69	26	29	124

Plan of Experiment to Test Validity of Information Obtained with Medical Needs Schedule

After the local medical society in each county had endorsed the project, and the local public health departments had agreed to assist with details, arrangements were made for the validation phase of the study. In each of the three counties a subsample of the families included in the study were asked to come to a clinic for a medical examination soon after the interview. The State Department of Health co-operated by providing facilities for chest x-rays, a blood test for syphilis, and laboratory services for analyzing urine specimens for albumen and sugar.

The Medical School of the University of Michigan co-operated by making available the services of physicians to do the examinations.‡ Approximately every sixth family interviewed with the schedule was selected in a random fashion and was asked to come to the clinic. Over 150 persons representing nearly fifty different families were examined. The examinations were carefully done, and thorough except for the fact that it was not possible to make a detailed check of eyes and teeth.

Comparison of Survey and Clinical Data

The results of these examinations are shown in Tables I and II. It is clear from the figures in Table I that in eight out of ten cases there was agreement between the findings of the medical examinations and the Medical Needs Schedule data

‡Dr. Rosalie Neligh made the examination in Shiawassee County with the assistance of Dr. Roelof Lanting, county public health officer. In Kent County Dr. Thomas Robinson did the examining. In Cheboygan County Dr. Neligh had complete charge of examinations.

regarding need for medical attention. In this table "need for medical attention" includes both met and unmet needs. If certain items are omitted, mainly those involving dental or visual problems, the numbers of cases of agreement are increased from 123 to 130 and the percentage of

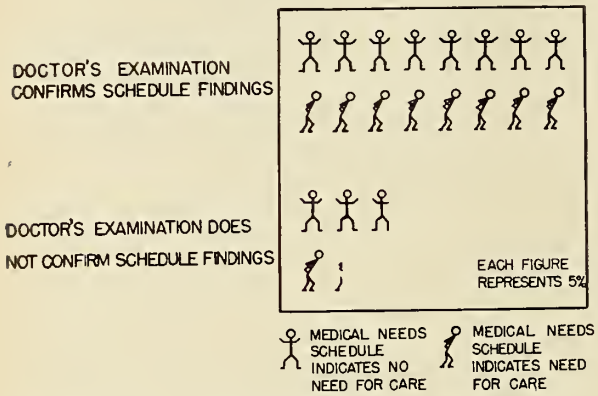

Fig. 1. Extent to which Medical Needs Schedule findings were confirmed by medical examination.

agreement rises from 80 to 85. But since this procedure cuts down on the number of cases of clear-cut medical need, it is not certain whether such exclusion would be preferable in future use of the Schedule. In any event the percentage of agreement seems sufficiently high to warrant use of the Medical Needs Schedule in appraising the unmet medical needs of a population.

When a comparison is made between the data reported on each symptom of the Medical Needs Schedule with the information obtained by the physicians, the results still show agreement for 76 per cent of the instances of positive symptoms. In other words, the examination confirmed the medical needs data regarding the advisability for medical attention for ninety-five reported symptoms, but did not do so in the case of twenty-nine reported symptoms. However, twenty-three of the twenty-nine unconfirmed symptoms were reported for individuals already classified as needing medical care on account of other confirmed symptoms. Of the six symptoms remaining, two involved individuals who had skin rashes. The others were discolored patches on the skin, running ears, poor vision, and pain in the joints. The details for this analysis according to symptoms are given in Table II.

The examinations by the physician revealed a total of six symptoms included in the Medical Needs Schedule that had developed after the schedule was taken and fourteen symptoms were found which were not reported to the interviewer. Besides these, there were fifty-three symptoms (involving thirty-nine individuals) not included in the Medical Needs Schedule which were reported by the examining physicians. It should be emphasized, however, that *twenty-seven of the thirty-nine persons were reported as needing medical care in connection with one or more ailments that were listed on the Medical Needs Schedule.*

Among the twelve individuals not so reported, three had high blood pressure, for which the doctor advised that a subsequent check be made. Of the remainder, one had goiter; one, pains below the shoulder (possible gall-bladder trouble); one, intestinal round worms; one, sugar in the urine; one, enlarged tonsils, but not sufficient to give symptoms; one, varicose veins; one, psychoneurosis; one, allergic rhinitis; and one, abnormal lungs.

The x-ray films showed one abnormal heart and two instances of abnormal lungs. The laboratory analysis of the urine specimens revealed, in addition to the one case of albumen already mentioned, one questionable Wassermann sample and five cases of sugar in the urine which, in the opinion of the examining physicians, indicated that a recheck was advisable. Except for instances noted in the above paragraph, individuals having these symptoms were reported as needing medical care in connection with an item listed in the Medical Needs Schedule.

The major conclusion derived from this experiment may be stated as follows: Correspondence between the data obtained with the Medical Needs Schedule and the medical examination and laboratory tests is so close that the Schedule can be used to establish a reasonably reliable measure of unmet needs for medical attention among farm families.

Reference

1. Schuler, Edgar A.; Mayo, Selz C., and Makover, Henry B.: Measuring unmet needs for medical care; an experiment in method. Rural Sociology, 11:152-158, (June) 1946.

MSMS

Little Joe Genius says—

I see that when Mr. Miller of the Federal Security Board was asked if the national compulsory health bill was socialistic, he said that he wished that he understood more about what that term means. Sometimes it is convenient to act dumb, deaf, and blind.

Functional Bleeding at Different Age Periods

Significance and Management

By Emil Novak, M.D.
Baltimore, Maryland

Uterine bleeding may be a symptoms of any one of a considerable array of anatomic lesions in the genital apparatus, or it may occur in the entire absence of any demonstrable structural change. With such destructive lesions as cancer of any part of the genital tract, the bleeding is readily enough explained by the actual opening up of blood vessels. In another group, lesions of one sort or another may be present, but they cannot through their mere presence explain the bleeding which is produced, so that a combination of anatomic and physiologic factors must be invoked. A granulosa cell tumor of the ovary produces bleeding because of the estrogen produced by its cells, and the bleeding of a tubal pregnancy is due to hormonal influences emanating from the site of the pregnancy. These examples might be multiplied.

In a third group of cases there is a disorder involving the intricate physiologic mechanism concerned in menstrual bleeding, with often no associated anatomic lesion. Even though some such lesion is coexistent, it plays no causative role in the bleeding. This is the functional type of bleeding with which we are especially concerned in this paper. Its clinical characteristics are well enough known so that they need not be discussed in this paper, which will be concerned chiefly with the significance and treatment of functional bleeding at various age periods.

Mechanism of Functional Bleeding

Either the common ovulatory cycle, or the much less frequent anovulatory type, may exhibit aberration. It would appear, however, that the anovulatory-type of menstruation is of more primitive and less stable character, and this is further suggested by the disproportionate frequency with which it is disordered. Not only may ovulation fail to occur, but the unruptured follicle may persist in actively functioning form beyond the usual time of ovulation, so that the endometrium is subjected to an abnormally persistent and relatively excessive estrogen influence, expressed characteristically by a growth effect. In some cases this takes the form of Swiss cheese hyperplasia; in others the growth effect is less marked. Progesterone is absent, since ovulation does not occur.

The above, at any rate, represents the immediate mechanism in those cases of functional bleeding designated as metropathia hemorrhagica, and this is the largest clinical group. A variation of the above-described ovarian change may occur, in that, instead of a single large persistent follicle, a considerable group of smaller follicles may persist functionally, producing the same abnormal estrogen persistence and excess. In either case the endometrium may be expected to show a purely proliferative picture, with none of the secretory characteristics which are dependent upon progesterone.

However, the bleeding is not due to the endometrial change, even though this be represented by extreme hyperplasia. The latter is simply an expression of the growth effect of estrogen, and, as I have repeatedly emphasized, there is no parallelism between these growth changes and the occurrence or amount of bleeding. We do not know the exact nature of the vascular participation in this disorder, although it is obvious that it must be mediated through the spiral arteriolar system of the endometrium. Nor can we assume that there is any mathematical relation between the degree of estrogen excess and either the growth or bleeding effect upon the endometrium, since endometria differs so widely in the degree of their responsiveness or refractoriness to the same estrogen stimulus.

What has been said thus far refers to the roles of only the ovary and uterus, but the ovarian dysfunction is clearly secondary to a more fundamental dysfunction of the anterior hypophysis. Just what the hormonal stimulus to normal ovulation is, is not definitely known, though the best evidence indicates that it is dependent upon a delicate quantitative balance of the two pituitary gonadotropic principles, that concerned with follicle stimulating (FSH), and that having to do with luteinization (L), these hormones motivating the production by the ovary of estrogen and progesterone, respectively.

The immediate factor in the production of the

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bleeding phases is the occurrence of periodic drops in the level of estrogen brought about by the reverse inhibition of the FSH principle whenever the estrogen level becomes sufficiently high. While there is some evidence to indicate that moderate dosage of estrogen may stimulate the gonadotropic function, there appears to be no doubt that excess of estrogen inhibits the pituitary function. As long as the endometrium is under the influence of a steady and sufficient amount of estrogen, it does not bleed, but when this estrogen support is withdrawn, endometrial and presumably vascular deterioration takes place, with the occurrence of bleeding. There is, therefore, nothing new in the concept that the endometrium will bleed if the estrogen level drops below a certain point, though this point cannot be expressed in mathematical terms because of wide individual variations.

This represents, in sketchy outline at least, our present-day concept as to the endocrine mechanism involved in the most common form of functional bleeding. I have discussed this topic more fully in a recent publication, which includes also a brief historical review of the development of our knowledge of this subject. It is certain that these views will be modified, or perhaps radically changed, as we learn more about the intricate interlocking relationship between the ovary and the pituitary, and about the vascular mechanism in the uterus itself.

In the recent paper alluded to above, I have stressed also the fact that a large proportion of our cases of functional bleeding do not fall into the category of metropathia hemorrhagica, and that the latter group of cases would be better designated as anovulatory functional bleeding, since they revolve around the anovulatory type of cycle. The ovulatory type of cycle may also undergo pathological aberration, so that in these, abnormal bleeding may be associated with even a progestational type of endometrium. While we may theorize that in such cases there may be a quantitative imbalance of the two ovarian hormones, the dysfunction may just as well involve the spiral arteriolar apparatus, or the vasomotor nerves, or the myometrium. In short, no satisfactory explanation is as yet available.

Management of Bleeding in Young Girls

When bleeding occurs in young girls, one will not make a great many mistakes in assuming that it is of so-called functional type. The occasional case due to other causes can as a rule be readily enough excluded by simple pelvic examination, and curettage is not usually indicated for diagnostic purposes, though it may be necessary for the prompt relief of bleeding if it has assumed serious proportions.

The interpretation of bleeding at this age epoch is simplified if one remembers that in a large proportion of girls the cycles are of anovulatory type for a short time, and not infrequently for a number of years after the menarche. This fact, incidentally, explains why another menstrual disorder, primary dysmennorhea, so often does not begin at the menarche, but a considerable time afterwards, since anovulatory menstruation is so characteristically unassociated with pain. On the other hand, many girls, probably the majority, begin to ovulate with the very first menstrual cycle. As to the relative incidence of the ovulatory and anovulatory cycles, no one can as yet speak authoritatively, because of lack of statistical evidence on this point.

Anovulatory menstruation may be of essentially normal clinical character, but more often it shows a tendency to irregularity of rhythm and, not infrequently, excess of flow. Many girls exhibit delay or skipping of flows, and the latter are often moderately prolonged and excessive. If the disorder is of moderate degree, it is quite certain, after a time, to correct itself, this meaning usually the inauguration of ovulation. These are instances of mild functional bleeding, many of which are not even brought to the doctor's attention.

On the other hand, the bleeding may be so profuse as to exsanguinate the patient, and in such cases transfusion, perhaps repeatedly, is often the first essential in treatment. Once the blood deficiency is reasonably well corrected, curettage is usually indicated, as it is the most effective and promptest means of checking the bleeding, at least temporarily. Furthermore, it yields the endometrium for microscopic examination, this usually showing some degree of proliferative, non-secretory change, not infrequently a typical Swiss-cheese hyperplasia.

Where the emergency is not so great, the bleeding can often be checked with reasonable promptness by large doses of estrogen, usually in the form of diethyl-stilbestrol. As much as 10 mg. a day can be given, and often the bleeding is completely or almost completely checked within two or three days. If the estrogen is then withdrawn, bleeding

is likely to return within a few days, so that it is better to keep up the diethyl-stilbestrol, but in gradually diminishing doses. When free bleeding phases recur, as they usually do, the dosage can again be increased. Since even large doses of the drug have no known harmful effect, this treatment can be kept up for long periods of time, always in the reasonably confident hope that sooner or later ovulation will begin, and menstruation will then assume a normal character and rhythm.

In the relatively mild cases, in which only moderate menorrhagia occurs, not sufficient to cause worthwhile anemia, progesterone may be chosen, since this is the hormone lacking in such cases. While this plan has been lauded by some (Allen and Heckel, and Smith), its results do not seem impressive, and a serious disadvantage is the considerable expense entailed by the large doses required. At least 5 and preferably 10 mg. daily by the hypodermic route are required, with from three to five times this dosage if the oral route is chosen. Personally I am likely to choose this method of treatment in only the mild cases, and even in these it is difficult to evaluate the results, since such cases often go on to spontaneous readjustment, with no treatment at all.

Another plan of treatment, lauded by some and cursed by others, is through the use of the androgenic hormones, in the form of testosterone propionate, which is perhaps the nearest approach we have to an anti-estrogen. As a matter of fact, I believe that this is likely to give better results than progesterone, and I am not one of those who inveigh against its use, appearing to look upon the androgenic hormone as a sort of contaminating factor to the female—this in spite of the fact that a regular curve of androgenic hormone, corresponding to the estrogen curve, is found throughout the woman's reproductive life, and that it may possibly even play a normal part in the menstrual cycle, though this has not yet been shown. To say that it is unphysiologic means very little, for in the present state of organotherapy it is difficult to say which method is physiologic and which is unphysiologic.

A more practical objection can be urged in the fact that testosterone, unless used cautiously, may produce hirsutism and other manifestations of virilism. This risk, however, should be practically nil if the dosage is kept below 200 mg. or, even better, 150 mg. monthly, and in my experience only such modest dosage is required. I have never, for example, seen such unpleasant manifestations with doses of 10 mg. three times a week. If even the careful employment of testosterone were frequently followed by even temporary masculinization symptoms, I for one would not feel its use justified, but this is not the case.

I shall not review the very elaborate and highly expensive plans of so-called cyclic therapy which have been recommended, especially by Hamblen and Smith. They are not practical for a large proportion of women who have to pay for the often huge doses of progesterone recommended, and they are based on a premise which I do not think infallible, since they aim to beat a sick and abnormally functioning pituitary into a sort of cyclical submission by the sequential use of the ovarian hormones, simulating what occurs during a normal cycle. The results are not invariably good, and I believe that many patients will conclude that the long rituals of treatment, including hypodermic injections many days in succession, are worse than the disease itself. Furthermore, I believe that simpler and less expensive plans will usually tide patients over until the hoped-for readjustment takes place.

As a matter of fact, I believe that in intractable cases most patients would prefer an occasional repetition of curettage, which almost always gives temporary and sometimes permanent relief, especially since this procedure can so readily be done without hospitalization.

I have said nothing as to the use of the chorionic gonadotrophic hormones, because I believe that one of the above-mentioned plans will usually give better results—this in spite of the fact that our own paper (1932) was, I believe, the first to be published on this subject in this country. Its employment, however, cannot be criticized, and it does seem to be helpful in a proportion of cases. Nor have I said anything as to the use of thyroid, since this substance, so often empirically used for so many indications, is rarely of value in functional bleeding unless a definite hypothyroidism exists, which is only occasionally the case.

Bleeding During the Reproductive Years

During the reproductive epoch, functional bleeding may occur at any age, and is subject to the same variations in severity and duration as have been discussed as regards the bleeding of young girls. The diagnostic problem, however, is not al-

ways so simple, because of the frequency of other intra-uterine causes of bleeding, even if no gross abnormality can be made out. Diagnostic curettage is therefore frequently necessary to rule out such conditions as incomplete abortion, submucous myoma or adenocarcinoma. If the curettings show only a normal endometrium of either non-secretory or secretory type, or one which is definitely hyperplastic, the bleeding may be assumed to be functional. Unless the bleeding has been very severe and of long duration, nothing further should be done, and one may wait to see how the patient will behave menstrually.

Not infrequently the curettage seems in some way to promote a restoration of the normal endocrine mechanism, so that no further menstrual excess will occur. All too often, however, the bleeding may recur either soon after the curettage or perhaps not for a good many months, so that one must resort to organotherapy. This need not be further discussed, since the plans already described for the adolescent girl are applicable for the somewhat older patient. When the patient is within a few years of the menopause, however, and especially when the bleeding has been prolonged and insistent, abolition of the menstrual function by radiotherapy will ordinarily be preferable to the uncertainties and disagreeableness of long-continued organotherapy, especially if this includes hypodermic medication. At just what age one will draw the line will be decided differently by different gynecologists, as will be discussed in the next section.

Bleeding in the Immediately Premenopausal and Menopausal Years

The significance of functional bleeding at this age is obviously greater than at any other, simply because it must be distinguished from the bleeding caused by other more serious conditions, including malignancy. When the patient presents herself with a history of increasing menorrhagia over a period of several years, with no intermenstrual bleeding and with grossly normal organs, the functional nature of the bleeding is highly probable, but even then should not be assumed. Much more uncertainty exists in cases in which menstrual excess is associated with persistent or irregular intermenstrual bleeding. It is not presumptuous to say that in practically all cases the cause of the bleeding can be definitely established by a combination of careful history, thorough pelvic examination and, in the absence of any ostensible uterine or extra-uterine pathologic condition, curettage and microscopic examination. Even the latter does not in most cases offer any difficulty except in a minority of cases in which it may be difficult to distinguish between proliferative and adenomatous but benign forms of hyperplasia and actual adenocarcinoma.

In this small group, which in my experience occurs especially often in women over fifty, the distinction is not always easy, and pathologists may differ in their interpretation. Those who have had large experience in this field, both clinical and pathological, can usually decide the question authoritatively, and the microscopic examination in some cases may almost be said to be based on empiricism and instinct. Even then there will be a small residue of cases in which there is doubt, and in these the indication is clear for panhysterectomy. In perhaps the majority of cases belonging to this category, in my experience, careful gross and microscopic examination of the removed uterus has failed to show any clear evidence of malignancy, but there have been some exceptions, and in this small group the operative plan is not only fully justified but clearly advisable.

It cannot be too strongly emphasized, however, that this is true in only a very small proportion of all the very numerous cases of functional bleeding encountered in the middle age group, and that the proper treatment of the vast majority is the safe and effective one of abolition of ovarian function by radiotherapy. There would seem to be no justification for hysterectomy for functional bleeding *per se* if the patient is in the terminal years of the reproductive epoch. On the other hand, if there is some other indication for laparotomy, such as a ventral hernia or a recurrent appendicitis, the sensible plan in most cases would be to do a hysterectomy at the same time.

There will be understandable differences of opinion as to what are to be looked upon as the terminal years of ovarian function, and it would be foolish to try to fix mathematical lines of demarcation. In the case of a women of thirty-eight or thirty-nine who suffers with intractable bleeding, and who has already had a number of children, most of us would prefer hysterectomy to x-ray induction of the menopause. There are some who would carry this surgical plan into the early forties, while others, including myself, feel that in

(Continued on Page 485)

Functional Hyperinsulinism

A Common and Well-Defined Clinical Entity Amenable to Medical Management

By J. W. Conn, M.D.
Ann Arbor, Michigan

SPONTANEOUS HYPOGLYCEMIA is the cause of a characteristic group of symptoms in a relatively large number of individuals. It is of greatest importance, from the therapeutic point of view, that the clinician be aware of the large number of abnormalities which are capable of producing periodic depressions of the blood sugar level. The following classification lists the many possibilities.

Etiological Classification of Spontaneous Hypoglycemia

I. Organic—recognizable anatomic lesion
- A. Hyperinsulinism
  1. Pancreatic island cell adenoma
     - (a) Single
     - (b) Multiple
     - (c) Aberrant
  2. Pancreatic island cell carcinoma
     - (a) Localized
     - (b) With metastases
  3. Generalized hypertrophy and hyperplasia of the islands of Langerhans
- B. Hepatic disease
  1. Ascending infectious cholangiolitis
  2. Toxic hepatitis
  3. Diffuse carcinomatosis
  4. Fatty degeneration, "Fatty metamorphosis"
  5. Glycogenosis (von Gierke's disease)
- C. Pituitary hypofunction (anterior lobe)
  1. Destructive lesions (chromophobe tumors, cysts, et cetera)
  2. Atrophy and degeneration (Simmond's disease)
  3. Thyroid hypofunction (? secondary to pituitary hypofunction)
- D. Adrenal hypofunction (cortex)
  1. Idiopathic cortical atrophy
  2. Destructive infectious granulomas
  3. Destructive neoplasms
- E. Central nervous system lesions (hypothalamus or brain stem; interference with nervous control of blood sugar)

II. Functional—no recognized anatomic lesion but explainable on basis of unusual *somatic* function
- A. Hyperinsulinism (imbalance of the autonomic nervous system) "Hypoglycemic fatigue"; "nervous hypoglycemia"; "functional hypoglycemia"; "reactive hypoglycemia," et cetera
- B. Alimentary hyperinsulinism (rapid intestinal absorption)
  1. Post gastroenterostomy
  2. Post gastric resection (partial or total)
- C. Renal glycosuria (severe degrees of low renal threshold for dextrose)
- D. Lactation
- E. Severe continuous muscular work

III. Miscellaneous
- A. Factitious (surreptitious insulin administration)
- B. Postoperative hypoglycemia
- C. Severe inanition
- D. Unknown

It is evident that successful management of the individual case of periodic spontaneous hypoglycemia is wholly dependent upon establishing the correct etiological diagnosis. Details of this problem have been discussed elsewhere.[6]

The purpose of this presentation is threefold:

1. To delineate the most common type of spontaneous hypoglycemia (functional hyperinsulinism) as a clear cut, easily recognizable syndrome possessing characteristic clinical and laboratory features.

2. To present the rationale for the use of the high-protein, low-carbohydrate diet in the control of functional hyperinsulinism.

3. To indicate the sharp clinical and laboratory differences which distinguish this condition from organic hyperinsulinism (pancreatic islet cell tumor); this constituting an effort to prevent unnecessary and useless pancreatic surgery in cases of functional hyperinsulinism.

Functional hyperinsulinism is by far the most common cause of periodic attacks of spontaneous hypoglycemia, accounting for about 70 per cent of all cases in which hypoglycemia is responsible for clinical symptoms.[6] The frequency of the syndrome soon becomes apparent to those who develop a diagnostic consciousness of its existence. The patient who complains, among other things of rather sudden, overwhelming attacks of severe weakness and fatigue occurring most frequently *in the forenoon* and *in the late afternoon* should be

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suspected of having functional hyperinsulinism. If on further questioning the weakness is found to be accompanied by other symptoms characteristically associated with a rapidly falling blood

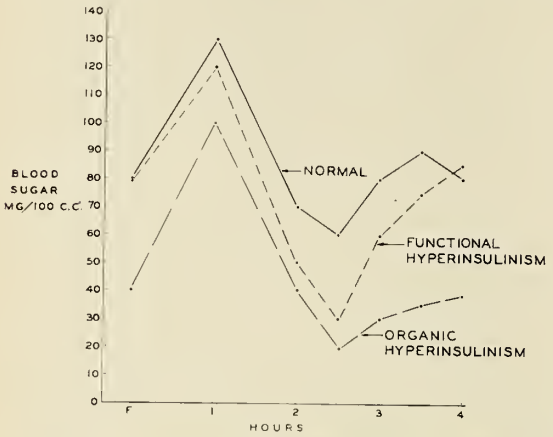

Fig. 1. Dextrose tolerance test (standard dietary preparation).

sugar level, such as, "inward trembling," pallor, sweating, palpitation, visual disturbances, loss of mental acuity or syncope, the suspicion of functional hyperinsulinism begins to gain strength. Although a gnawing discomfort in the epigastrium is common, a clearly defined sensation of hunger is not. Nevertheless, the patient usually discovers that all of his symptoms disappear rapidly after the ingestion of a candy bar or a sweet beverage or, in fact, of any kind of food. If no food is taken, symptoms gradually increase in severity for from ten to thirty minutes and then subside spontaneously. It is important to inquire also as to the occurrence of "pre-breakfast" attacks (2 A.M. to 8 A.M.) since hypoglycemic episodes at this time, although common in other types, *do not occur in functional hyperinsulinism.*

Such a story must often be dissected and pieced together from a mass of apparently unrelated symptoms which, justifiably in many cases, have already led to a diagnosis of an anxiety type of psychoneurosis. The periodicity of symptoms, their intensification during periods of emotional tension, and their amelioration during periods of relative emotional tranquillity, all suggest a relationship between functional hyperinsulinism and psychogenic factors.

Laboratory Findings

A blood specimen obtained at the beginning of an attack is usually found to contain 40 mg. to 60 mg. of glucose per 100 c.c. Because the period of hypoglycemia is of relatively short duration, however, it is frequently difficult to obtain this evidence, unless the patient is hospitalized for this express purpose. Fifteen to thirty minutes after the onset of the attack, the blood sugar level will have returned to within the normal range.

Daily fasting blood sugar determinations will be found to be consistently normal. Satisfactory evidence of functional hyperinsulinism may be found, however, in the results of a standardized* glucose tolerance test. Figure 1 represents a typical example of the response obtained in these patients and compares it with an average normal curve. The fasting blood sugar level is in the normal range. The absorptive rise is either normal or somewhat subnormal. The secondary depression, however, occurring usually from two to four hours after the ingestion of glucose, is excessive. During this short period the patient frequently experiences the same symptoms as those about which he had complained. The blood sugar level then rebounds rapidly and the symptoms disappear in fifteen to thirty minutes.

Such a response, differing from the normal only in the depth of the hypoglycemic phase, is characteristic of functional hyperinsulinism. The problem of choosing an arbitrary level of hypoglycemic depression which is diagnostic of the condition is difficult because first, there is great variation among individuals with regard to the level of blood sugar at which hypoglycemic symptoms appear, and secondly, a given patient subject to such hypoglycemic episodes frequently responds to ingested glucose with different degrees of secondary hypoglycemia at different times. In the author's experience the following diagnostic criteria (with regard to the secondary hypoglycemic phase of the glucose tolerance test) have been satisfactory. It is taken for granted that the earlier portions of the curve are of the type described above, that is, a normal fasting blood sugar followed by a normal or subnormal hyperglycemic phase.

Secondary Hypoglycemic Phase of the Glucose Tolerance Test

Lowest Level of Blood Sugar	*Interpretation*
0-39 mg. %	Diagnostic }
40-49 mg. %	Presumptive } of functional hyperinsulinism
50-59 mg. %	Suggestive }
60-69 mg. %	Low normal range

*Adequate dietary preparation[4]; glucose 1.75 gm./kilo. orally; blood samples every ½ hour for four hours.

Mechanism

The great variety of names (functional hyperinsulinism, reactive hypoglycemia, nervous hypoglycemia, hypoglycemic fatigue, functional hypoglycemia, et cetera) which have been attached to this syndrome affords evidence of the disagreement regarding its modus operandi. All agree, however, that the fundamental disturbance consists of an instability of the autonomic nervous system, the latter normally being responsible for the finer and prompt adjustments of the blood sugar level. For reasons outlined elsewhere[6] it is our belief that the type of autonomic imbalance obtaining in these individuals gives rise to an *excessive responsiveness of the islet of Langerhans* to the normal stimulus for insulin production. Hence, we adhere to the term functional hyperinsulinism.

That the normal absorptive rise of the blood sugar level constitutes a normal stimulus for the production of insulin has been well established.[13] It is for this reason that two to three hours after the ingestion of carbohydrate, normal people frequently demonstrate a blood sugar level which is somewhat lower than it had been in the fasting state (Fig. 1). In functional hyperinsulinism the normal stimulus (absorption of glucose) calls forth excessive secretory activity of the *histologically normal islet cells.* If a high-carbohydrate breakfast is eaten, the patient may have his hypoglycemic attack in the late morning. But, if he fasts or if he takes bacon, eggs and unsweetened coffee for breakfast (see Management) no hypoglycemic episode occurs. Thus, it requires the stimulus of carbohydrate absorption to produce the *characteristic post-prandial attacks* which these patients experience. The absence of attacks before breakfast or upon the omission of a meal and the constantly normal fasting blood sugar levels are explainable upon the same basis. The therapeutic objective, then, must be to prevent absorptive elevations of the blood sugar level which are in turn responsible for the secondary hypoglycemic dip that follows. Paradoxical as it may seem at first glance, this type of spontaneous hypoglycemia is treated, among other things, by restriction of dietary carbohydrate.

Mention has been made of an apparent relationship between this form of spontaneous hypoglycemia and psychic factors. That the syndrome may represent a somatic expression of a psychogenic disturbance has been expressed by others.[1,19] Be that as it may, it is heartening to both patient and physician to obtain rapid relief of distressing symptoms by dietary means.

Differentiation from Organic Hyperinsulinism (Pancreatic Insuloma)

Functional hyperinsulinism, a relatively common cause of spontaneous hypoglycemia, is the condition which is most frequently confused with the rare disease, organic hyperinsulinism. This constitutes an unfortunate circumstance since it leads to pancreatic surgery in patients with functional hyperinsulinism where no indications exist for such a procedure.† Yet the diagnostic distinction between the two conditions is rather simple. It is based upon the fact that in organic hyperinsulinism the production of insulin is continuously excessive[7,15], while in functional hyperinsulinism it is excessive spasmodically and only in response to a physiological stimulus, as described above. Thus, differential criteria have been established both from the clinical and laboratory points of view.

Differential Diagnosis

I. *Clinical Distinction*	*Functional Hyperinsulinism*	*Organic Hyperinsulinism*
1. The time of the day that attacks characteristically occur	2 to 4 hours post-prandially. No pre-breakfast attacks	Pre-breakfast attacks frequent. Episodes also occur 2 to 4 hours post-prandially
2. Effect of omission of a meal	Does not produce hypoglycemia	Likely to produce severe atack
3. Progression of attacks (frequency and severity)	Not progressive. Characterized by remissions and exacerbations.	Relentlessly progressive
II. *Laboratory Criteria*		
1. The fasting blood sugar level	Normal	Subnormal (below 50 mg. %)
2. Provocation of hypoglycemia by fasting or by CHO restriction	Not abnormally depressed	Markedly depressed (below 40 mg. %)
3. The glucose tolerance curve	See Figure 1.	See Figure 1.

Thus, functional hyperinsulinism becomes an easily distinguishable syndrome. Conversely, a diagnosis of organic hyperinsulinism can be made with a great deal of certainty.[6] With regard to management of the latter condition, suffice it to say here that surgical removal of excessive amounts of islet tissue constitutes the only successful method developed to date. Various attempts at medical management, sound theoretically, have proven to be of little or only temporary value.[8,11]

†The surgeon's failure to disclose an insuloma at operation usually results in a decision to resect a major portion of the pancreas. Thus, to explore a patient with functional hyperinsulinism is to foredoom him to loss of most of his pancreas unnecessarily.

Management of Functional Hyperinsulinism

Soon after it became apparent that absorptive hyperglycemia, incident upon the ingestion of carbohydrate, was the trigger which fired the hypoglycemia-producing mechanism, and that a high-carbohydrate diet was likely to intensify rather than to relieve attacks, Waters[23] introduced the use of a low-carbohydrate diet. Clinical results were much improved by this regimen which, however, necessitated a frequent feeding schedule. John's demonstration[17] that a small dose of insulin, so administered as to prevent an absorptive hyperglycemia, prevented the secondary hypoglycemia as well, gave added support to the modus operandi but had obvious therapeutic disadvantages.

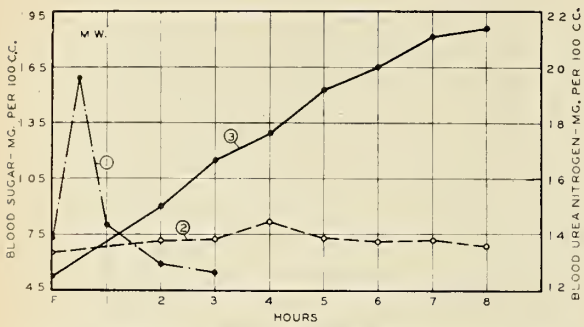

Fig. 2. Laboratory findings in normal individuals. (1) Blood sugar after 66 gm. glucose. (2) Blood sugar after 600 gm. lean beef (132 gm. protein), (66 gm. available glucose). (3) Blood urea nitrogen after 600 gm. lean beef (132 gm. protein).

Ten years ago the writer reported experimental and clinical evidence indicating the additional advantages to be derived from a diet containing large amounts of protein[5] and introduced the use of the high-protein, low-carbohydrate diet. Figures 2 and 3 illustrate the metabolic principle upon which the high-protein, low-carbohydrate regimen is based. Protein during its metabolism yields approximately 50 per cent of its weight as glucose. Yet in normals (Fig. 2), in patients with functional hyperinsulinism (Fig. 3), and even in the average diabetic[12], no significant rise in the blood sugar level is demonstrable after the ingestion of protein. Note that with equivalent yields of glucose from protein on the one hand and from carbohydrate on the other, the blood-sugar time curves are entirely different. Carbohydrate is absorbed quickly and directly into the blood stream, producing a rapid initial elevation of the blood sugar and a secondary hypoglycemia. Protein is split in the intestinal tract and absorbed into the blood as amino acids. In the liver the glycogenic amino acids are deaminized and converted to glucose. That this is a slow and even process is indicated by the prolonged, steady rise of the blood urea nitrogen levels after the ingestion of protein. The release of glucose is thus sufficiently slow that an elevation of the blood sugar does not occur. Consequently a secondary hypoglycemia is not produced despite the fact that an amount of glucose has been added to the body from a protein precursor which is equal to a hypoglycemia-producing dose when given as carbohydrate.

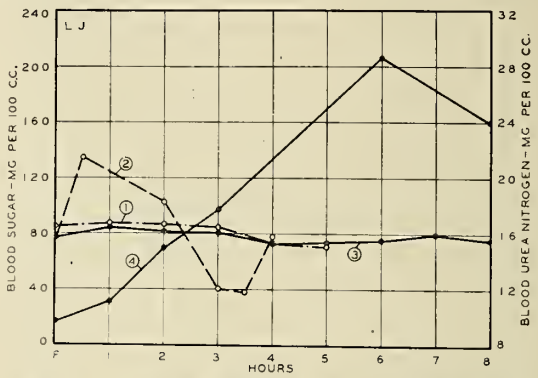

Fig. 3. Laboratory findings in patient with functional hyperinsulinism. (1) Blood sugar fasting (test begun after twelve-hour fast). (2) Blood sugar after 59 gm. glucose. (3) Blood sugar after 545 gm. lean beef (120 gm. protein), (60 gm. available glucose). (4) Blood urea nitrogen after 545 gm. lean beef (120 gm. protein).

This principle has since been confirmed experimentally by Thorn.[22] Many[3,14,16,18,20,21,24] have reported recently upon the therapeutic efficacy of the high-protein, low-carbohydrate regimen in the management of functional hyperinsulinism. Our own results continue to be good. The average case responds promptly and completely after two or three days of dietary control. We use a three-meal program, prescribing as much protein as the patient can comfortably handle. This averages about 120 to 140 grams per day. The carbohydrate is initially limited to between 50 and 75 grams and is divided evenly among the three meals. The remaining calories required for maintenance are supplied by fat. Beeuwkes[2] has reported upon the dietetic aspects of this regimen. A sample menu is presented below.

Sample Menu

2600 calories, 75 gm. CHO, 130 gm. Pro.

Breakfast

Orange juice—½ cup
Eggs—2 scrambled
Butter—1 tablespoon
Bacon—4 strips

Half-and-half milk and cream—1 cup
Coffee
Saccharin if desired

Dinner

Roast chicken—6 oz.
Tomato salad
  Mayonnaise—1 tablespoon
Green beans—½ cup
  Butter—1 teaspoon
Cantaloupe—¼ average
Milk—¾ cup
Cream—¼ cup
Coffee or Tea

Supper

Bouillon
Steak—6 oz.
Head lettuce salad—¼ head
  Russian dressing—1 tablespoon
Squash—½ cup
  Butter—1 teaspoon
Blackberries—⅓ cup
Milk—¾ cup
Cream—¼ cup
Coffee or Tea

Summary

Of the many causes of spontaneous hypoglycemia, functional hyperinsulinism is the most common. While relatively innocuous *per se,* it produces distressing symptoms which respond well to dietary management. Failure to recognize and treat the syndrome leads to erroneous diagnoses and persistence of symptoms. Where low blood sugar levels are actually discovered, improper classification may lead to major pancreatic surgery for which there is no indication.

A diagnostic consciousness of the existence of functional hyperinsulinism constitutes the first requirement for its recognition. Clinical and laboratory criteria for diagnosis are available, as are differential points separating the rare case of islet cell tumor that requires pancreatic surgery from the relatively frequent case of functional hyperinsulinism that does not.

A diet high in protein and low in carbohydrate produces dramatic relief of symptoms in functional hyperinsulinism. Mechanisms by which this apparently paradoxical dietary relieves hypoglycemia are discussed in detail.

References

1. Alexander, F., and Portis, S. A.: A psychosomatic study of hypoglycemic fatigue. Psychosom. Med., 6:191-206, 1944.
2. Beeuwkes, A. M.: The dietary treatment of functional hyperinsulinism. J. Am. Dietet. A., 18:731-733, 1942.
3. Brown, M. J.: Hypoglycemia and abdominal pain. Am. J. Surg., 64:276-281, 1944.
4. Conn, J. W.: Interpretation of the glucose tolerance test. The necessity of a standard preparatory diet. Am. J. M. Sc., 199:555-564, 1940.
5. Conn, J. W.: The advantage of a high protein diet in the treatment of spontaneous hypoglycemia. J. Clin. Investigation, 15:673-678, 1936.
6. Conn, J. W.: The diagnosis and management of spontaneous hypoglycemia. J.A.M.A., (In press).
7. Conn, J. W., and Conn, E. S.: Metabolism in organic hyperinsulinism. I. Quantitative studies of the variations in the rate of combustion of carbohydrate produced by alterations in the diet. Arch. Int. Med., 68:876-892, 1941.
8. Conn, J. W., and Conn, E. S.: Metabolism in organic hyperinsulinism. II. Effects of epinephrine upon glycemic levels and upon combustion of carbohydrate. Arch. Int. Med., 68:1105-1114, 1941.
9. Conn, J. W., and Conn, E. S.: Metabolism in organic hyperinsulinism. III. Effects of adrenal cortical extract upon blood sugar and upon sodium and nitrogen equilibrium. Arch. Int Med., 68:1115-1119, 1941.
10. Conn, J. W., and Hinerman, D. L.: The effects of alloxan in organic hyperinsulinism. (In press.)
11. Conn, J. W., and Louis, L.: A pituitary insulotropic principle. J. Clin. Endocrinol., 5:247-258, (July-Aug.) 1945.
12. Conn, J. W., and Newburgh, L. H.: The glycemic rseponse to isoglucogenic quantities of protein and carbohydrate. J. Clin. Investigation, 15:665-672, 1936.
13. Cori, C. F.: Mammalian carbohydrate metabolism. Physiol. Rev., 11:143-275, 1931.
14. Dyer, W. W.: Masked hypoglycemia. Pennsylvania M. J., 47:1210-1212, 1944.
15. Frazer, R.; Maclay, W. S., and Mann, S. A.: Hyperinsulinism due to a pancreatic "islet adenoma." Quart. J. Med., 31:115-135, 1938.
16. Harrison, T. R., and Finks, R. M.: Glucose deficiency as a factor in the production of symptoms referable to the cardiovascular system. Am. Heart J., 26:147-163, 1943.
17. John, H. J.: A case of hyperinsulinism treated with insulin. Endocrinology, 17:583-586, 1933.
18. Leiberman, A. A.: Nervous and mental manifestations observed in spontaneous hypoglycemia. Illinois Med. J., 85:287-292, 1944.
19. Rennie, T. A. C., and Howard, J. E.: Hypoglycemia and tension depression. Psychosom. Med., 4:273-283, 1942.
20. Schneider, R. W., and Anconda, V. C.: Hyperinsulinism and functional hypoglycemia. Cleveland Clin. Quart., 12:34-40, 1945.
21. Smith, H. L., and Estes, J. E.: Spontaneous hypoglycemia. J. Michigan M. Soc., 44:711-714, 1945.
22. Thorn, G. W.; Quinby, J. T., and Clinton, M., Jr.: A comparison of the metabolic effects of isocaloric meals of varying composition with special reference to the prevention of postprandial hypoglycemia symptoms. Ann. Int. Med., 18:913-919, 1943.
23. Waters, W. C., Jr.: Spontaneous hypoglycemia: The role of diet in etiology and treatment. South M. J., 24:249-252, 1931.
24. Wilder, R. M.: Clinical Diabetes Mellitus and Hyperinsulinism. Philadelphia: W. B. Saunders Co., 1940.

MSMS

ON THE RUN . . . .

The early morning pains of peptic ulcer may be due to hypoglycemia with its associated increase in gastric secretion.

* * *

In bulbar poliomyelitis the higher the spinal fluid sugar content the worse the prognosis.

* * *

Patients with penicillin-treated early syphilis are far more difficult to hold than under the old treatment regime.

* * *

Patients with hookworm do not develop anemia in the presence of an adequate iron balance.

* * *

Newborn babies may develop pneumonitis if the mother has a common respiratory infection at time of delivery.

* * *

Older patients with liver secondaries from colonic malignancies may live comfortably for two or three years if the primary lesion is removed.

* * *

In auricular fibrillation mechanical reduction of venous pressure will produce as great an improvement as digitalis.

Selected by W. S. Reveno, M.D.

Editorial

S. 545

We now have to learn another number of a bill in which the whole medical profession and the public in general are interested. Senator Taft and Senators Smith, Ball and Donnell have introduced "The National Health Act of 1947," which was twice read and referred to the Committee on Labor and Public Welfare.

We mentioned the introduction of this bill before but were unable to give a digest of it, not having the printed copy which has now arrived. The bill is forty-seven pages long. Every doctor should send to his Congressman for a copy, and then read it carefully. The first two pages are introductory, recognizing that there are many scattered agencies in the government with health and medical functions.

Title I creates the "National Health Agency" in the executive branch of the government, to be independent, appointed by the President. The Administrator "shall engage in no other business, vocation or employment, shall be a doctor of medicine, licensed in one or more states and who is outstanding in the field of medicine." The purpose of the agency is to promote the general welfare of the people of the United States by aiding and fostering progress . . . in the field of health and medicine and by centralizing in the Agency the activities of the Federal Government relating to health. To carry out these purposes the Agency shall (1) encourage the development throughout the Nation of health services and facilities, (2) advise and co-operate with other agencies, and departments of government, federal and State, and with private agencies functioning in the field of Health, (3) collect, analyze, and disseminate statistics, and make studies, investigations and reports on conditions in the United States and other countries, (4) make reports and recommendations as to the most efficient policies and methods for promotion of health, and (5) carry out specific duties referred by Congress, et cetera. The Agency shall have responsibility for a list of seven groups of activities. The activities and functions of the Administration are carefully and exhaustively defined.

The Agency shall be composed of seven units which shall be co-equal in rank: (1) the office of the Administrator, (2) the Public Health Service including Saint Elizabeth's Hospital and Freedmen's Hospital, (3) the office of Medical and Hospital Care Services, (4) the office of Dental Care Services, (5) the office of Maternal and Child Health, (6) the office of Health Statistics, (7) the Food and Drug Administration, and (8) such other units as the Administrator finds necessary.

Title II. Necessary amendments to the Public Health Service Act.

(There are no intervening titles)

Title VII. *Part A.* Medical Care Survey. Services on a State level, on State application, with $3,000,000 appropriated to carry on these surveys.

Part B. Medical Care Services. In order to assist the States to provide general health, hospital, and medical services for families and individuals with low incomes, there is appropriated for five years the sum of $200,000,000 each, beginning with the year ending June 30, 1948. Any State desiring to take advantage of this title must designate a single State agency, and "provide for the designation by the Governor of a State medical and hospital care advisory council which shall include representatives of non-government organizations or groups, and of State agencies concerned with the administration or utilization of health, medical, or hospital services, including representatives of State Medical Associations, State hospital associations, voluntary non-profit prepaid medical care plans, voluntary non-profit hospital care plans, or other groups interested in the improvement of medical and hospital services."

"Such program may, at the option of the State, provide medical care services in institutions, in the home, or in physicians' offices, or may provide for furnishing of such services by means of payments in the nature of premiums, or partial premiums or reimbursement of expenses or otherwise, by the State to any voluntary health, medical, or hospital insurance fund, or other fund, operated not for profit, in behalf of those families and individuals unable to pay the whole cost of such services or insurance."

Title VIII provides for Dental Health Services for school children and families with low income. Provisions are much on the order of medical services, only limited.

Title IX provides further research and training. *Part A.* Dental Research; *Part B.* New Construction for Research.

Title III, which comes at the end, is miscellaneous, defining terms, authorizing payments from the treasury, and authorizing the deduction of stated amounts from the salary of any officer or employe of the government to be paid to any voluntary non-profit health insurance fund.

This or a similar bill will be passed. We must live with it.

PROPAGANDA

THE FEDERAL GOVERNMENT has a great staff of individuals, we are told, whose duty it is to advertise the Government, and promote its ideas and activities. Various sums have been mentioned as going into this propaganda machine, sums of staggering amounts. Such may be the case, and we are inclined to believe the rumors.

One agency of the Government, we know, is engaged in such propaganda, and has been for years—The Children's Bureau. This is the department that has been administering the much berated EMIC program, the one which the doctors have had to service, or do their work free for the mothers and children of the lower grades of servicemen. EMIC was established, we were told, for the duration of the war and six months. We foresaw that this termination would be long extended. Senator Pepper wants to make it eternal, and to cover all mothers and children. So does the Children's Bureau, formerly of the Department of Labor, but now of the Social Security Administration, Federal Security Agency.

We have just received a news release, for editors generally, containing over seven thousand words, painting in glowing terms, the needs and services for women and children. Dramatic descriptions include the story of the returned army air officer who secured a plane, flew his pregnant wife to a hospital, and alighted in a creek bed, so she could have good care, also the unmarried, pregnant negro girl of sixteen who had to be admitted to an "insane asylum," as there was no other place for her.

All this is to advertise the Children's Bureau, and make a spectacular appeal. The article points out that foresight eleven years ago in placing a small appropriation in the Social Security Act was an act of "tremendous import."

The January, 1947, issue of *Elks Magazine* has an article by Senator Robert F. Wagner advocating compulsory health insurance. His article is full of insidious arguments tending to mislead, and trying to bolster the Wagner-Murray-Dingell philosophy. Wagner has in no way lessened his attempts to put across a scheme for domestic economy far foreign to American ideals and standards. To place the profession in an unfavorable light he has gone back to 1937, and has quoted the old Bureau of Economics of the American Medical Association, when they did not know the score, but the rest of us were groping for the light with some degree of success. Do you remember:

> "Without some form of compulsion, voluntary insurance fails of its objective of distributing the cost of sickness among large classes of the population with even approximate fairness. The young and healthy will not join, and the aged and sick, if accepted, will raise the cost to a prohibitive point and, if rejected, remove protection from those most in need. Sickness insurance cannot distribute the burden of sickness among the low income classes unless it is compulsory."

That idea was abandoned many years ago, but the grime still sticks, and the argument is being used to prove the medical profession "not in harmony with progressive modern trends."

Wagner also says:

> "The American people do not want the kind of medical care plan proposed in Senator Taft's bill, S.2143. His plan makes provision only for those who can meet some kind of an income test. . . . A government "handout" for medical care, for millions of persons of low incomes, with all, its humiliating investigating of incomes, would turn us back a half century in social progress."

That is exactly what Wagner's bill does, but he fails utterly to care for the medically indigent.

Senator Wagner's new bill has not been introduced, but he has announced that it is in preparation. Small Wagner-Murray-Dingell bills are being considered in some of the states. We had been warned that Michigan would be a trial ground, but so far nothing has developed.

Those who would like to socialize medicine, or who would further the cause of compulsory health insurance, are well backed by *our* funds in the keeping of the government, which are being used for propaganda. We must meet this action by such publicity as we may. The medical profes-

sion is now happily beginning to get some breaks in the matter of favorable stories in public print. We have spent immense sums for radio and other advertising, and we must spend vastly more if we are to compete successfully with the unlimited funds of the socializing government bureaus.

RURAL HEALTH SERVICE

RURAL MEDICINE, and the placing of doctors for care of rural communities, has become a major problem. Another annual conference has been held in Chicago under the auspices of the American Medical Association, and we are featuring a report of that meeting by one of the Councilors of the Michigan State Medical Society. He attended, officially representing the State Medical Society Committee on Rural Health, and has written a very comprehensive report. We have available the speeches made at the Conference, and meant to abstract them, but that has been done by one who heard them.

We hope our members will read the material mentioned. It is full of thought-provoking hints and should stimulate more study. Rural health is necessary if we are to have urban health, because this great state is so constituted that each type of citizenry is interdependent. And they cannot reasonably be separated. The problem as seen by most of those attending this conference is one of getting doctors of medicine into areas where the population is scattered or less productive of returns, be they monetary or cultural.

It has been proposed in Michigan in other years that communities provide a subsidy for the doctor who will locate in their midst, but this has not succeeded. There is one community that we know of now looking for that very relief, and without success. Inquiries have been made for the benefit of returning veterans, and some have gone to the rural areas, but as many more have moved into the cities.

The Committee on Rural Medical Service of the Illinois State Medical Association has made a suggestion for training more doctors for rural practice. It is suggested that the legislature appropriate $50,000 to be used for scholarships of $7,000 each to be made available to students from rural areas with the prerequisite education. Students are to be recommended by a Senator or Representative and by the superintendent of schools of a rural area, and must sign a contract to practice in the rural area at least until they have repaid the loan.

There is an advantage in this proposal in that it would call upon the legislature to provide a revolving fund, it would secure a medical education to some young persons who otherwise might not be able to finance it, and it would assure a small number of doctors to rural areas for a varying number of years.

One can see merit in the plan, and a contract that the young doctor can terminate as soon as his ambitions may provide the necessary sacrifice, or determination. The rural areas would profit by the very latest medical ability and service, and the cost to the state would be negligible.

The plan was proposed in one of the Chicago papers in February, with a statement from one of the legislators that he would be willing to introduce the bill. This might be a worthwhile plan for Michigan.

Another feature that will help in this problem is the sale of Blue Cross services, hospital and medical, to these rural areas. Attempts have been made to stimulate these sales in Michigan, and four areas were canvassed. They were suspended, however, by orders of the State Insurance Commissioner prohibiting sales of hospital service policies for several months, due to the financial condition of the plan. That has now been remedied, the financial structure is completely satisfactory, and the permission for renewal of sales has been granted. We anticipate renewed efforts to sell these plans to the farm organizations and groups. Some thousands of new policies among the rural groups would go far to relieve the hardship of farmers and their families.

Rural health needs are of the first importance, and we hope they will get first consideration. Our doctors in the smaller cities and rural counties have been clamoring for medical service to be sold in their areas, so that they and their patients could benefit. We hope that demand may soon be met (with substantial benefits). The officers of our Blue Cross have not been idle. As of December 31, 1946 there were 360 farm bureau groups covered by Michigan Hospital Service, with 18,051 members, and Michigan Medical Service had 124 groups with 3,188 members, Michigan Hospital Service also has twenty-three Grange groups with 450 members.

Detroit Physiological Society

Session of February 5, 1947

The Lipotropic Factors in the Protection of Liver and Kidneys

C. H. Best, C.B.E., M.D., F.R.S., Department of Physiology and the Banting and Best Department of Medical Research, University of Toronto.

It has now been established that adequate diets, i.e., of protein, fat and carbohydrate and all the known vitamins, with the exception of choline or substances which form choline in the body, result in the production of profound changes in the appearance and in the function of the liver and kidneys of experimental animals. The application of these findings to human subjects is still obscure —first, most human diets, in North America at least, have adequate amounts of choline or precursors of choline available in them; second, it is not possible to place human subjects on a diet free of these lipotropic factors because dangerous lesions might be produced.

With hypolipotropic diets deposition of fat in the liver in excess of the normal amounts, is seen very quickly and this goes on until huge deposits are present. If the animal is maintained for longer periods on these diets, cirrhotic changes may take place in the liver. Choline, or its precursors, is a specific in the prevention of these cirrhotic lesions (Gyorgy; Sebrell, Blumberg and McCallum).

When cirrhosis is produced by toxic agents, choline and the other lipotropic factors are moderately effective in preventing the development of this lesion. A more dramatic demonstration is, however, the failure of these fatty and cirrhotic abnormalities to disappear unless some source of choline, or its precursors, is present in the diet.

The changes in the kidneys in choline-deficiency are of great interest. They were first observed by Griffith and Wade and they consist of a fatty degeneration of the cells of the proximal convoluted tubules followed by swelling and necrosis of these cells with cast formation. These kidney changes in young animals can be completely prevented by the addition of 1 or 2 milligrams of choline per day to the diet.

Historically, the development of the lipotropic factors is a direct outgrowth of the discovery of insulin. In Professor Macleod's laboratory in Toronto and in Fisher's in Chicago, insulin-treated depancreatized dogs were found to develop large fatty livers. Minced pancreas in the diet prevented these lesions. Hershey and Soskin reported from my laboratory that crude egg-yolk lecithin could be substituted for the pancreas, and Huntsman and I showed that the active component of lecithin was choline. We also found the choline-like effect of betaine and of protein. Tucker and Eckstein of Ann Arbor, Michigan, showed that the effect of protein was in large part due to its methionine content. Du Vigneaud and his collaborators proved that the transfer of the methyl group from methionine to another substance, resulted in the formation of choline. Stetten and his colleagues showed that the substance receiving the methyl group was amino ethyl alcohol. A part at least of the action of choline in preventing the deposition of fat in the liver, or accelerating the rate of removal, is due as Chaikoff and his group showed, to the increased rate of turnover of the liver phospholipids when choline is given.

The pancreas which was fed during the early observations on depancreatized dogs, has now been shown to produce its effect through a variety of actions. It contains appreciable amounts of choline and methionine. Furthermore as Chaikoff, Entenman and Montgomery have shown, some component of pancreatic juice and presumably also of pancreas, prevents fatty livers in the insulin-treated depancreatized dog, probably by liberating methionine from the protein in the diet. This factor is probably a proteolytic enzyme.

In some countries there is evidence that the human diets are deficient in the lipotropic agents and that this may be responsible, in part at least, for the high frequency of cirrhotic changes. In other countries where the diets are more adequate there is unlikely to be a deficiency of choline but there may be abnormalities which interfere with its absorption or with its effective utlization. It should be remembered that the recovery of human patients from liver abnormalities, such as fatty changes and cirrhosis, is probably due, in part, to the lipotropic agents which are contained in adequate amounts in a normal diet.

Michigan State Medical Society

PROCEEDINGS OF ANNUAL SESSION OF THE COUNCIL

Detroit, January 30, 31, February 1, 1947

The 1947 annual session of The Council was held at the Book-Cadillac Hotel, Detroit. Most of the 18 Councilors and Officers who were present arrived in Detroit via rail due to one of the worst blizzards experienced by Michigan in many years. Councilor A. H. Miller of Gladstone was snowbound on his train for thirty-one hours near Green Bay, Wisconsin.

Annual Reports Presented

Secretary L. Fernald Foster, M.D., Bay City; Treasurer A. S. Brunk, M.D., Detroit; Editor Wilfrid Haughey, M.D., Battle Creek, and Trustee Wm. A. Hyland, M.D., Grand Rapids, presented their annual reports (published in March JMSMS). The three standing committees and various special committees of The Council rendered their reports. Also received were progress reports from the MSMS Committee on Postgraduate Medical Education, Venereal Disease Control, Rheumatic Fever Control, Iodized Salt, Infectious Diarrhea, Legislation, and the House of Delegates' Commission on Health Care.

Committee Appointments

President Wm. A. Hyland, M.D., presented the following appointments to MSMS Committees, which were confirmed by The Council:

(a) *Committee on Nurses Training Schools.*—C. G. Clippert, M.D., Grayling, Chairman; D. W. Thorup, M.D., Benton Harbor; W. D. Barrett, M.D., Detroit; W. Joe Smith, M.D., Cadillac; R. L. Haas, M.D., Ann Arbor.

(b) *Professional Liaison Committee.*—W. D. Mayer, M.D., Detroit, Chairman; H. B. Zemmer, M.D., Lapeer; C. E. Lemmon, M.D., Detroit.

(c) *Committee on Uniform Fee Schedule for Governmental Agencies.* (Additions)—R. V. Walker, M.D., Detroit; E. C. Baumgarten, M.D., Detroit; E. C. Texter, M.D., Detroit; Arch Walls, M.D., Detroit; W. E. Johnston, M.D., Detroit.

(d) *Annual Session.*—General Chairman—B. R. Corbus, M.D., Grand Rapids; Housing Committee Chairman—J. W. Logie, M.D., Grand Rapids; Scientific Exhibit Chairman—C. D. Benson, M.D., Detroit.

Council Chairman E. F. Sladek, M.D., presented the following appointments to Special Committees of The Council, which were confirmed:

(a) *Study Committee on Federal Hospital Construction Act Implementation.*—R. V. Walker, M.D., Detroit, Chairman; C. W. Colwell, M.D., Flint; L. A. Drolett, M.D., Lansing; L. Fernald Foster, M.D., Bay City; T. K. Gruber, M.D., Eloise; S. L. Loupee, M.D., Dowagiac; and R. H. Pino, M.D., Detroit.

(b) *Advisory Committee to the Bureau of Maternal and Child Welfare, Michigan Department of Health.*—Frank Van Schoick, M.D., Jackson, Chairman; R. M. Kempton, M.D., Saginaw; Campbell Harvey, M.D., Pontiac; A. E. Catherwood, M.D., Dertoit; Harold Henderson, M.D., Detroit; W. G. Hoebeke, M.D., Kalamazoo; P. W. Willits, M.D., Grand Rapids; S. L. Loupee, M.D., Dowagiac; Willard Klunzinger, M.D., Lansing; and Wilfrid Haughey, M.D., Battle Creek.

Annual Audit—Budgets

The Ernst and Ernst reports of the MSMS audit for the year 1946 were presented, thoroughly studied and approved.

The detailed MSMS budgets for 1947 were developed and approved.

Michigan Medical Service

MSMS President R. L. Novy, M.D., presented a progress report on operations of Michigan Medical Service stating that its financial condition is most satisfactory and the Board of Directors is looking forward to writing much new business in 1947. The program of hometown medical care of veterans, in which Michigan Medical Service is co-operating with the Veterans Administration, is working smoothly; more than 54,000 cases were handled through MMS from March 1,

(Continued on Page 486)

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TYPICAL ANALYSIS

Protein	15.3%
Fat	6.8%
Carbohydrate	65.1%
Fiber	1.9%
Ash	4.7%
	(Per Ounce)
Calories	108
Calcium	216 mg.
Phosphorus	278 mg.
Iron	6.6 mg.
Thiamine	0.3 mg.
Riboflavin	0.051 mg.
Niacin	0.41 mg.

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Michigan's Department of Health

Wm. De Kleine, M.D., Commissioner, Lansing, Michigan

POLIO CHECKED

The poliomyelitis epidemic which started in Michigan last July and continued through February, peaking in late August, is considered over, with no new cases having been reported to the Michigan Department of Health in a seven-day period ending March 5.

It was the longest polio epidemic in the history of the state. It was the third largest epidemic of the disease since 1930 and it took second high number of lives.

The epidemic which caused the death of 89 persons and partial paralysis of at least 614 others included 1,082 reported cases in 1946 and 24 reported cases this year.

The 1946 case fatality rate was 8.22 in comparison with a state and national average of five.

MICHIGAN STUDY CITED

The goiter surveys conducted by the Michigan State Medical Society and the Michigan Department of Health in 1924 and 1935, before and after the introduction of iodized salt, are cited in an editorial of the February 22 issue of the *Journal of the American Medical Association* as substantiation for the need for national standardization of table salt to contain a preventive amount of iodine.

STUDY SCHOOL VISUAL CONDITIONS

To promote better visual conditions for children in Michigan schools, a series of institutes for school administrators, public health personnel, architects and engineers will be held throughout the state in April. These institutes will be under the joint sponsorship of the Michigan Department of Health and the State Department of Public Instruction.

Charles Gibson, school planning representative of the California Department of Education, will conduct eighteen meetings. He will discuss recent research to show that proper distribution and control of natural and artificial light, together with reduction of contrasts between areas of high and low brightness can prevent eye difficulties among children and result in better learning rates.

DRUG AGAINST TUBERCULOSIS

The Michigan Department of Health will try to make streptomycin available to those tuberculosis patients in Michigan who can be successfully treated with it. The Commissioner of Health recently discussed this matter with a group of physicians experienced in the treatment of tuberculosis.

It is recognized that streptomycin is effective only in certain forms of tuberculosis including: military tuberculosis, meningitis, genito-urinary, extra pulmonary with sinus tracts, bronchial lesions, infection of second lung after thoracoplasty, and empyemas with evidence of tuberculosis.

KELLOGG EARMARKS TRAINING FUND

Of the $162,083.80 which the W. K. Kellogg Foundation recently transferred to the Michigan Department of Health for continuation of the Foundation's participation in its seven-county health project, $72,000 was earmarked for the field training of public health personnel in the area.

The remaining $90,083.80 is to assist in financing the basic programs of Allegan, Barry, Branch, Calhoun, Eaton, Hillsdale, and VanBuren county health departments.

The Foundation also granted $4,740 to the Department to assist in defraying expenses of a public health nursing consultant for the nurses' training program in the state.

MICHIGAN LEADS

Michigan is a leader among states in the manufacture and distribution of biologic products for the control of disease. In one year more than two and a half million doses of these products are prepared and sent out by the Michigan Department of Health. They include serums and vaccines for the prevention of diphtheria, smallpox, whooping cough, typhoid and tetanus.

INCIDENCE OF COMMUNICABLE DISEASE

Disease	*February 1947*	*February 1946*	*7-year median*
Diphtheria	21	70	16
Gonorrhea	939	1202	637
Lobar Pneumonia	90	82	257
Measles	493	7851	984
Meningococcic meningitis	14	20	20
Pertussis	880	469	539
Poliomyelitis	9	1	2
Scarlet fever	620	605	1004
Syphilis	1428	1384	834
Tuberculosis	495	400	406
Typhoid fever	3	1	5
Undulant fever	18	5	7
Smallpox	0	0	2

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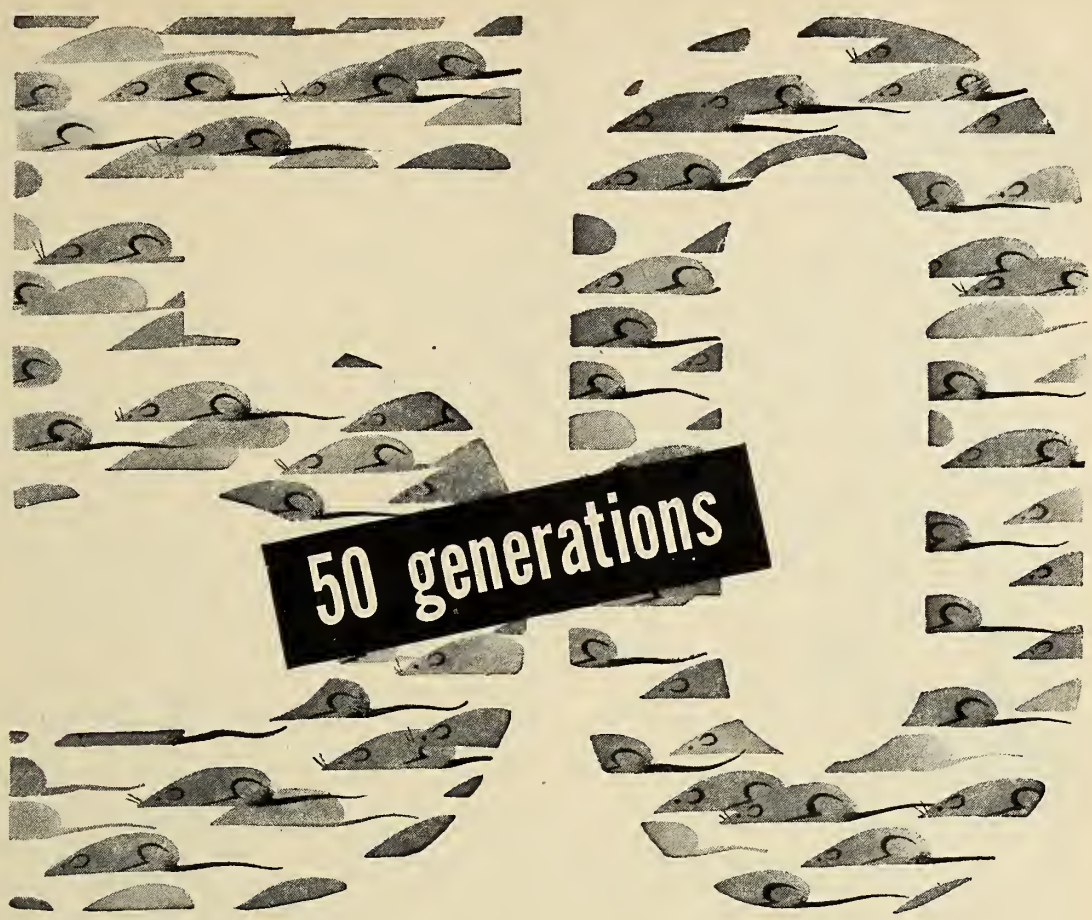

When the diet of 50 generations of rats was improved, it was found that they gained a longer average life span and longer "prime of life"[1] with "increased growth and efficiency, decreased death rate and increased vitality at all ages." Without waiting 50 generations, "the size and health of our young adolescents"[2] and increased longevity[3] amply confirm the fact "that the science of nutrition has made vast strides."[2] For the present generations and those to come, Upjohn provides, and will continue to provide, the finest in vitamins, in forms and dosages to fill the needs of medical and surgical practice.

1. National Research Council Bull. No. 109 (Nov.) 1943, p. 36.
2. Southern M. J. **3**:172 (Feb.) 1946.
3. Statistical Bull. Metropolitan Life Ins. Co. **27**:6 (Dec.) 1946

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Communication

MEDICAL OFFICERS NEEDED IN RESERVE CORPS

To the Editor:

An acute shortage of Medical Department Officers in all categories, Medical, Dental, Veterinary, Sanitary, and others, exists in the Organized Reserve of the Armed Forces. In Michigan only 60 per cent of the number of Army Medical Officers are available to man presently authorized Army units, and it is not anticipated that all the available officers will accept appointments.

The Armed Forces of the U. S. consists of the Regular Army, Navy and Marine Corps, National Guard and Reserve Corps. While the Reserve Corps is the third echelon for National Defense it is an extremely important and necessary one. The U. S. has been divided into Army areas. Michigan is one of the twelve states in the 5th Army area with headquarters at Chicago. The headquarters for the Michigan area is in Detroit, at 472 Federal Bldg., Detroit (26) the Officer in Charge being Col. John W. Cotton, Inf. He has been directed to organize certain Army Reserve units in the Michigan area. If all Army Medical Corps Officers who elected to join the Reserve Corps of the Army at time of separation were to accept appointment in these units, only 60 per cent of what is needed would be available. This, it seems, is a challenge to the Medical Veterans of Michigan. Doctors must make an effort now to inform themselves of the needs of National Defense and take an active part in forming a medical policy for the future. This will not only aid the National Defense but the medical profession as a whole.

The army units to be formed in the organized Reserve will be classified as A, B and C units. The A unit being the most active and C unit the least active. Assignment to a C unit will require attendance at regular meetings but should not inconvenience the officer seriously. Several medical units are planned for Michigan. These units should be attractive for the doctor who wishes to maintain his Reserve status. Although an officer may be in the Reserve Corps and not assigned to a training unit and maintain his Reserve commission by a minimum of correspondence work; to be considered eligible for promotion he should not only complete the required correspondence subcourse work, but must have an efficiency rating in keeping with the high standards necessary and which can be attained through assignment to a unit.

Medical officers who on separation from the Army did not elect to join the Reserve Corps are urged to reconsider their decisions and to apply for a Reserve Commission. This can be done by applying to the Headquarters of the Michigan area at the address already referred to. All medical veterans should be active

(Continued on Page 472)

WHEN CHRONIC ILLNESS INCREASES THE NUTRITIONAL NEEDS

Chronic disease, whether febrile or neoplastic, imposes many additional metabolic demands upon the organism. Paradoxically, appetite is apt to wane at this time, making satisfaction of these requirements difficult. In consequence, weakness becomes excessive and the ability to resist secondary infection is impaired.

Because it contains all of the nutrients known to be essential, the dietary supplement made by mixing Ovaltine with milk can play an important role in augmenting the intake of the very nutrients needed. This nutritious food drink provides biologically adequate protein, readily utilized carbohydrate, highly emulsified fat, B complex and other vitamins including ascorbic acid, and the essential minerals iron, calcium, phosphorus. Its delicious taste assures patient cooperation, since it is taken with relish, even when most other foods are refused.

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FAT	31.5 Gm.	RIBOFLAVIN	2.00 mg.
CARBOHYDRATE	64.8 Gm.	NIACIN	6.8 mg.
CALCIUM	1.12 Gm.	VITAMIN C	30.0 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
IRON	12.0 mg.	COPPER	0.50 mg.

*Based on average reported values for milk.

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(Continued from Page 468)

enough in the Reserve (or National Guard if they choose) to merit promotion and to keep themselves informed regarding the problems of our National Defense. We must not relax with the thought that the recent emergency will be the last. Other emergencies may occur. Such is our National History and when an emergency does occur, doctors can have only themselves to blame if their grade, pay and conditions of service are not to their liking.

All Reserve Medical Officers of the Army, Navy, Marine and Coast Guards should join the Reserve Officers Assn. This large body of Reserve Officers has been fighting the problems of the Reserve Corps for many years. The Reserve officer is on the threshold of obtaining much needed legislation to improve his status, the most important perhaps being a retirement plan for the Reserves. The Reserve Officers Association can speak with maximum force and authority only if a majority of Reserve Officers are members. All Reserve Officers therefore are urged to join their nearest chapter. If you do not know your nearest chapter, contact the Surgeon (see below for address) or write to Lt. Col. Roy Eklund, Cavalry Reserve, President Michigan R.O.A., 25th floor Penobscot Bldg., Detroit, Michigan. This organization exists to further National Defense and to improve the status of the Reserve Officer.

In summary, the following recommendations are made:

1. All medical corps veterans are urged to join the Reserve Corps if they are not now members.

2. Those doctors who were not in the Service but who wish to join the Reserve Corps and who feel they may be eligible should write to the Headquarters of the Michigan Military District (see above for address)

3. All Reserve Medical Officers are urged to join the Reserve Officers Association in order that their past and future problems can be ironed out for their benefit and the furtherance of National Defense.

4. Veteran Medical Officers may join the Reserve Officers Association as "Associate" members even though they are not Reserve Officers. If you do not wish to be a Reserve Officer, it is recommended that you give support to the Reserve Officers Association that is trying to fight your problems for you.

R. D. MUDD, M.D.
Surgeon, Michigan Department
Reserve Officers Association.

1001 Hoyt Street,
Saginaw, Michigan.

Little Joe Genius says—

I see where Senator Wagner says 40 per cent of the counties in the United States do not have a full-time health officer. Maybe the voters in those counties don't want one.

Little Joe Genius says—

I see where Senator Pepper reported a committee report that was not reported by the committee. That is one way for a chairman to have his own way.

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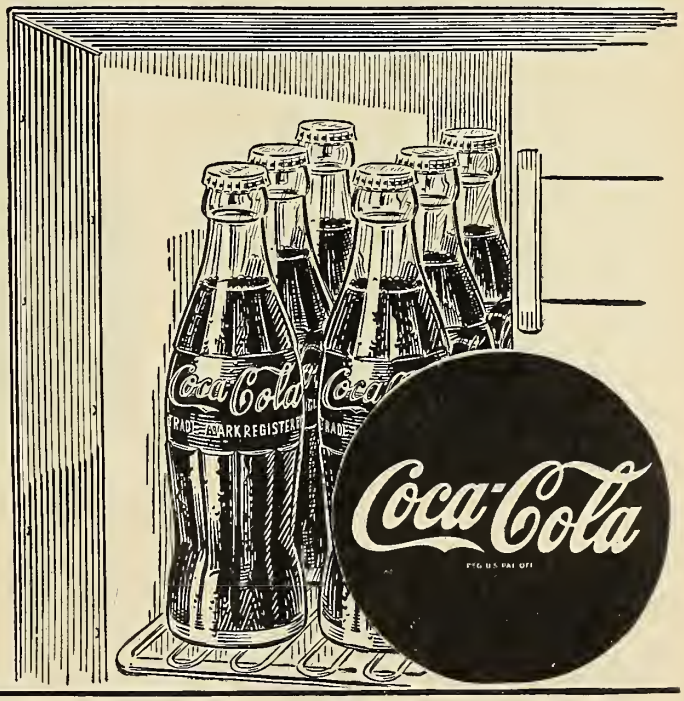


What's What

Renew your Federal narcotic license on or before July 1, 1947. Send check to Bureau of Narcotics, Federal Bldg., Detroit.

* * *

L. A. Drolett, M.D., Lansing, addressed the East Lansing Women's Club on March 10 on "Cancer Control Work in Michigan."

* * *

L. Fernald Foster, M.D., MSMS Secretary, addressed the Rotary Club of Pigeon, Michigan on February 24. His subject was "Health for the American People."

* * *

Taft-Ball-Smith-Donnell Bill (S.545) will allocate to the State of Michigan for implementing its national aid to a state plan for care of the needy $6,977,000.00.

* * *

State Medical Society of Wisconsin is sponsoring legislation to aid in the distribution of physicians in sparsely settled areas of the state by giving the Wisconsin Board of Health power to appoint special medical officers on a part-time basis; also a bill to permit the construction of homes for rheumatic fever cases.

* * *

The American College of Chest Physicians will hold its 13th annual meeting at the Ambassador Hotel, Atlantic City, N. J., June 5 to 8, 1947. For program as well as information on written and oral examinations for Fellowship, write John R. Phillips, M.D., 500 N. Dearborn Street, Chicago 10, Illinois.

* * *

Prize Contest.—The American Association of Obstetricians, Gynecologists and Abdominal Surgeons announces a foundation prize contest. For further information write to Dr. James R. Bloss, Secretary, 418 Eleventh St., Huntington, West Virginia.

* * *

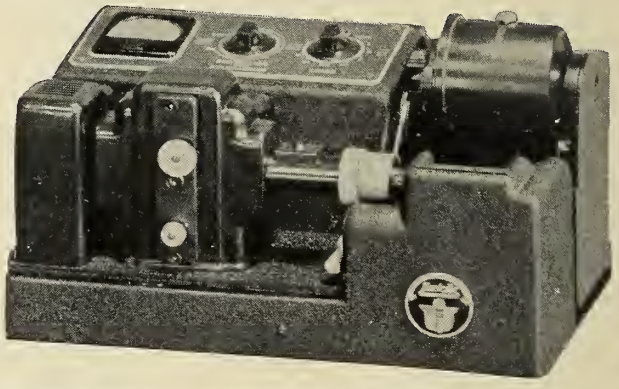
According to Washington correspondence, Britain's present plight of having too little manufacturing to take care of maximum exports will delay other plans of the labor government, such as the socialization of other parts of the economy (including medical care).

* * *

Senator Claud Pepper has introduced another bill—this time it's S.465, to provide medical care and treatment and hospitalization for dependent members of the family of any veteran of any war of the United States, as government supported facilities. The dependents would pay for the services at rates to be determined in the same manner as now prescribed by the President for hospitalization of dependents of Naval and Marine

(Continued on Page 476)

the new BECK-LEE MODEL E
Electrocardiograph



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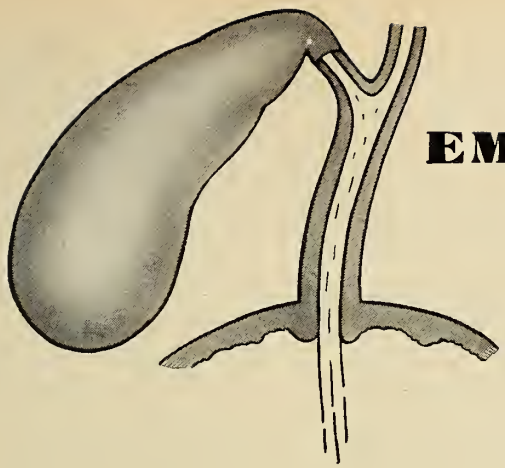

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(Continued from Page 474)

Corps personnel at any Navy hospital. The bill broadens the law somewhat in that services may be contracted for where a government facility does not exist.

* * *

H. H. Cummings, M.D., Ann Arbor was appointed to the Tuberculosis Sanatorium Commission by Governor Sigler on February 22. Dr. Cummings succeeds the late James D. Bruce, M.D., for the term ending October 9, 1947. Dr. Cummings is Past-President of the Michigan State Medical Society and present Chairman of the MSMS Committee on Postgraduate Medical Education.

* * *

The American Association of Industrial Physicians and Surgeons will hold its 32nd Annual Convention in Buffalo, New York the week of April 27-May 3, 1947. Headquarters will be at the Statler Hotel. For program and detailed information, write E. C. Holmblad, M.D., Managing Director, 28 E. Jackson Blvd., Chicago 4, Illinois.

* * *

MSMS is remitting the dues of all members still in military service, as well as those who were separated from service during the last half of 1946 or any time during the year 1947—no MSMS dues or assessments for 1947 will apply to these medical officers—provided *their names are certified to the State Society, 2020 Olds Tower, Lansing 8, Michigan by the county society secretary.*

* * *

The British Medical Journal of February 22, 1947, consisted of one sheet of very gray paper, *mimeographed on both sides.* The leading editorial is entitled "By Candlelight" and states: "This, the smallest BMJ since 1840, has been 'printed' on hand operated duplicators in BMA House, by permission of the Ministry of Fuel and Power and the COI. Our 'printer' is the secretary of the BMA."

* * *

Veterans Administration reports a total of 119,845 veterans receiving treatment in VA hospitals and homes and in non-VA hospitals under contract to VA, as of February 9, 1947. This compares with 92,276 veterans hospitalized one year ago.

Women veterans are entitled to the same medical care as male veterans. In addition they may receive hospitalization for *non-service* connected disabilities.

* * *

Dr. Milton H. Erickson, Director of Psychiatric Research and Training at Wayne County General Hospital and Infirmary, Eloise, Michigan, and Associate Professor of Psychiatry at the Wayne University College of Medicine, Detroit, Michigan, delivered a lecture on the Psychodynamics of Human Behavior at the University of Western Ontario, London, Ontario, Canada, on the evening of March 12.

* * *

E. F. Sladek, M.D., of Traverse City, Chairman of The Council of the Michigan State Medical Society, was honored by being elected as Secretary of the National

(Continued on Page 478)

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(Continued from Page 476)

Conference on Medical Service at its February 9 meeting in Chicago.

The Secretary automatically becomes President of the Conference after one year. Dr. Sladek, therefore, will preside at the 21st meeting of the National Conference on Medical Service, Palmer House Chicago, on Sunday, February 8, 1948.

* * *

The Academy of General Practice of Wayne County was formally inaugurated at the David Whitney House, headquarters of the Wayne County Medical Society, on February 13. Approximately 100 general practitioners attended the inaugural dinner and meeting and adopted a Constitution and By-Laws for the new organization.

Arch Walls, M.D., was chosen President of the Academy, E. C. Long, M.D., Vice President, E. C. Texter, M.D., Secretary, and Harold F. Reynor, M.D., Treasurer.

* * *

A Little History—

1. Medical registration was first required in Michigan in the year 1900, after the Michigan Legislature passed the Medical Practice Act in 1899.

2. The Michigan State Medical Society was incorporated in 1902. However, the first Michigan Medical Society was organized at Detroit under territorial law on August 10, 1819. It had but two breaks in its continuous operation, viz: from 1851 to 1853, and 1860 to 1866. Its name varied slightly during these three periods, but it has been, under all conditions, the Michigan Medical Society.

* * *

The Seventh Councilor District held a meeting in Marlette on March 20 under the chairmanship of Councilor T. E. DeGurse, M.D., Marine City.

J. Duane Miller, M.D., Grand Rapids, Councilor of the Fifth District spoke on "Medical Matters in Michigan." He was followed by L. Fernald Foster, M.D., Bay City, Secretary of the Michigan State Medical Society, who spoke on "The Federal Hospital Construction Program." H. W. Brenneman, Lansing, MSMS Public Relations Counsel, presented "Modern Medical Public Relations." Fifty-three members of the Seventh Councilor District were present.

* * *

National Conference of County Medical Society Officers.—This first annual conference, sponsored by the American Medical Association, will be held in Atlantic City on Sunday, June 8, the day prior to the Centennial of the AMA, in the American Room of the Traymore Hotel.

A. M. Mitchell, M.D., Terre Haute, Indiana, is chairman of the AMA Committee on Arrangements and D. Bruce Wiley, M.D., Utica, is chairman of the Michigan Committee.

All county society officers are cordially invited to

(Continued on Page 480)

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One-week, Surgery of Colon and Rectum starting April 7, May 5, June 2.
Two-week, Surgical Anatomy and Clinical Surgery starting April 14, May 12, June 9.
Two-week, Surgical Pathology every two weeks.

GYNECOLOGY—Two-week intensive course starting April 14, May 12, June 16.
One-week course in Vaginal Approach to Pelvic Surgery starting April 7, May 5, June 9.

OBSTETRICS—Two-week intensive course starting April 28, June 2.

MEDICINE—Two-week intensive course starting April 7, June 2.
Two-week Gastroenterology starting April 21, June 16.
One-month course Electrocardiography and Heart Disease starting June 16, September 15.

DERMATOLOGY AND SYPHILOLOGY—Two-week course starting April 14, June 16.

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(Continued from Page 478)

attend the Conference. Those planning to be present are urged to advise Dr. Wiley, with a notation as to what hotel they will use in Atlantic City. A program of the Conference will be mailed to all who advise they are planning attendance.

* * *

The Streamliners of the Pere Marquette Railroad will be much in demand on Tuesday, Wednesday, Thursday, and Friday, September 23-24-25-26—on the occasion of the MSMS 1947 Annual Session in Grand Rapids.

The General Assembly periods have been so arranged that they will be very convenient to those arriving by Streamliner from the southeastern part of the State. The Annual Session will run from Tuesday noon to Friday noon.

Thirty-one eminent teachers and clinicians from all parts of the United States and Canada will grace the program of the 82nd Annual Session of the Michigan State Medical Society.

* * *

Associate membership for young physicians whose training was interrupted by military service.—The Council of the Michigan State Medical Society, at its recent annual session, adopted the following ruling to cover physicians in this classification:

"Any physician heretofore eligible for Associate Membership under Article III, Section 4—(2) of the MSMS Constitution, whose training was interrupted by active military service may, after five years from the date of receiving his first medical degree (M.D. or M.B.), be certified by a county society to the MSMS as an active member. If so certified such physician will be accorded remission of dues for that period of time necessary for and continuously spent in completing his intern, resident, or teaching fellow training, provided, however, that such remission period shall not exceed the actual time spent on active military duty."

* * *

The Fifth Councilor District meeting is scheduled for Grand Rapids at the Morton Hotel on Tuesday, May 13. The meeting will be opened by President W. R. Vis, M.D., of the Kent County Medical Society.

Councilor J. Duane Miller, M.D., Grand Rapids, will be chairman of the day and will present President Wm. A. Hyland, M.D., Grand Rapids, who will discuss "Medical Matters in Michigan." President-Elect P. L. Ledwidge, M.D., Detroit, will present "Some Legislative Problems Facing the Medical Profession of our State." "The Implementation of the Federal Hospital Construction Act in Michigan" will be outlined by Secretary L. Fernald Foster, M.D., Bay City. E. R. Witwer, M.D., Councilor, Detroit, will speak on "Modern Medical Public Relations—and You."

* * *

Securing contacts of infectious cases of venereal disease.—The MSMS Venereal Disease Control Committee reports that the primary weakness in the V.D. control program is the lack of co-operation from practicing physicians in securing source and contact information on infectious cases of V.D. The failure to report even active infectious cases still remains a major problem. The Committee wisely points out that it is increasingly

(Continued on Page 482)

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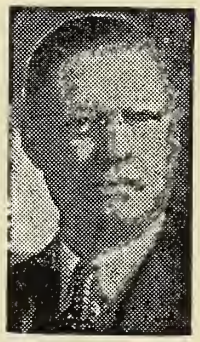

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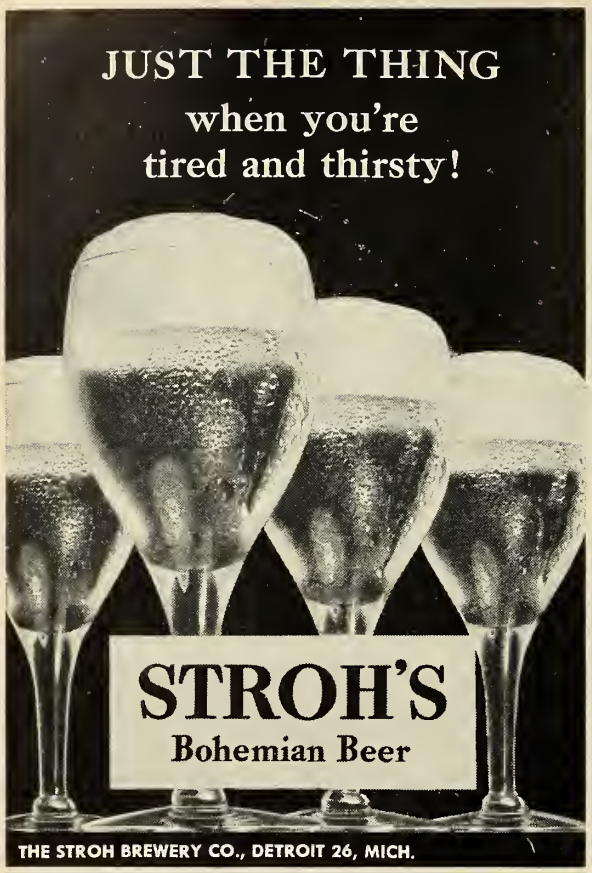

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(Continued from Page 480)

important for the individual doctor of medicine to accept his responsibility in this regard to the community as well as to his patient. Such co-operation will minimize the necessity for governmental coercion. The irresponsibility of a few physicians reflects disastrously upon the entire profession, and, according to the Committee, gross infractions of recognized laws and of ethical principles have been reported, especially with respect to the premarital and prenatal examination laws. The V.D. Control Committee has requested the Michigan Department of Health to report infractions to the officers of county medical societies for possible referral to ethics committees.

* * *

Cancer Talks—

1. H. J. VandenBerg, M.D., Grand Rapids, spoke to the Reed City Rotary Club, the high school in the afternoon, and the Parent-Teacher Association on April 9, on "Cancer Control."

2. A. A. Humphrey, M.D., Battle Creek, addressed a meeting of the Parent-Teacher Association in Onsted, Lenawee County, March 19. His subject was "Modern Cancer Control Methods."

3. R. L. Haas, M.D., Ann Arbor, spoke to the Ingham County Medical Auxiliary March 17 on "Michigan's Cancer Control Program."

4. F. L. Rector, M.D., Ann Arbor, spoke to the Child Study Club, Lansing, February 27, to the Junior College, Flint, on March 6, and to the Child Study Club of North Ann Arbor on April 7 on "Cancer and How to Detect It."

* * *

"Tell Me, Doctor," the new transcribed MSMS radio presentation currently being broadcast on a six-day week schedule, is a five-minute presentation featuring the latest in health news of both a scientific and socio-economic nature. The interlocutor is Franklin Ferguson, a top NBC narrator. It is gaining a large listening audience rapidly. Sixteen of the larger radio stations of the state sold the program to local sponsors within the first week of its release; two additional stations are arranging times on their schedules. This will mean a coverage of the entire state so complete that any person in Michigan who can hear a Michigan radio station will be able to tune in this program.

The Medical Society of Virginia, upon hearing of "Tell Me, Doctor," unique in its concept and distribution, requested permission to broadcast the series over ten Virginia stations. In gladly granting permission, the Executive Committee of The Council instructed that the program be made available to any other state medical society to use in view of the fact that the program material is authentic health news with the majority of it coming from national sources.

* * *

Council and Committee Meetings—

Committee on Rates and Fee Schedules under MCCC, Detroit January 3.

Sub-Committee on Michigan Postgraduate Clinical Conference, Ann Arbor, January 3.

(Continued on Page 484)

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(Continued from Page 482)

Joint Committee on Infectious Diarrhea, Detroit, January 8.
Committee on Rheumatic Fever Control, Ann Arbor, January 18.
Committee on Postgraduate Medical Education, January 18.
Commission on Health Care, Detroit, January 22.
Legislative Committee, Lansing, January 22.
Iodized Salt Committee, Detroit, January 24.
Committee on Venereal Disease Control, Lansing, January 26.
Sub-Committee of Legislative Committee on Afflicted Adult Bill, Detroit, January 30.
Committee on Rheumatic Fever Control, Detroit, January 30.
The Council, Detroit, January 31-February 1.
Members, Michigan Foundation for Medical and Health Education, Detroit, February 1.
Committee on Uniform Fee Schedule for Governmental Agencies, Detroit, February 1.
Board of Trustees, Michigan Foundation for Medical and Health Education, Detroit, February 1.
Public Relations Committee, Detroit, February 1.
Committee on Medical Economics Courses, Detroit, February 2.
Special Study Committee on Hill-Burton Bill, Detroit, February 2.
Sub-Committee of Legislative Committee on Afflicted Adult Bill, Grand Rapids, February 17.
Executive Committee of The Council, Detroit, February 19.
Mental Hygiene Committee, Detroit, February 20.
Committee on Uniform Fee Schedule for Governmental Agencies, Detroit, February 26.
Sub-Committee on Hospital Licensing Bill, Detroit, March 4.
Commission on Health Care, Detroit, March 5.
Committee on Venereal Disease Control, March 5.
Executive Committee of The Council, Detroit, March 11.
Michigan Postgraduate Clinical Conference, Detroit, March 12-13-14.
Committee on Tuberculosis Control, Detroit, March 13.
Committee on Heart and Degenerative Diseases, Detroit, March 13.
Committee on Rheumatic Fever Control, Detroit, March 13.
Preventive Medicine Committee, Detroit, March 20.
Legislative Committee, Lansing, April 10.

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Paralysis of the Larynx

(Continued from Page 442)

are disappointing. A certain number of patients prefer to wear a tracheal cannula equipped with a valve contrivance so that air is inspirated through the cannula but is forced out through the normal airway, thus providing a normal voice.

Recently there have been devised operations to improve the airway but with some sacrifice of the voice. These are mobilization and lateral fixation of an arytenoid (King) or arytenoidectomy and lateral fixation of a vocal cord (Kelly). These mark distinct advances in our treatment of bilateral paralysis and should be recommended in all patients with bilateral paralysis. There is some impairment of the voice, but patients, previously dyspneic, are more concerned about an adequate air supply than about a normal voice.

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(Continued from Page 450)

most patients over forty the radiotherapeutic induction of what is probably only a slightly premature menopause is wiser. Individual factors will often crop up to sway the preference in either direction, but there should be some definite and rational indication for the selection of hysterectomy in women during the fifth decade.

Hysterectomy, usually a simple enough operation, is never free of at least a slight hazard even in the hands of expert surgeons. There is not the slightest doubt that far too many hysterectomies are being done throughout the country, and it scarcely needed the recent analytical study made by Miller of the hysterectomies done in a group of midwestern clinics to convince one on this point. Just as in the field of general surgery, unnecessary and often ill-advised appendectomy is a prevalent evil, so in the field of gynecological surgery, unnecessary hysterectomy and resection or removal of "cystic ovaries" are equally prevalent and equally censurable.

Summary

Functional bleeding, one of the most common of gynecological disorders, is due to aberration of either the ovulatory or non-ovulatory types of cycle, the latter proportionately much more often than the former. To the anovulatory group belongs the so-called metropathia hemorrhagica of Schröder, for which a simpler and more expressive designation would seem to be anovulatory functional bleeding. The varying mechanism of functional bleeding has been discussed in the paper, as has been the varying endometrial histology which may be encountered.

The management of functional bleeding at different age periods has also been considered, since the age of the patient and the importance or unimportance of conserving the menstrual and reproductive functions are so important in the selection of the methods of management. The still unsatisfactory organotherapy to which resort must so commonly be made in the younger group of patients has been briefly reviewed, and comment made upon the frequent ill-advised resort to hysterectomy, even in women in the fifth decade of life, in which much simpler and safer plans would suffice to effect a cure.

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PROCEEDINGS ANNUAL SESSION OF THE COUNCIL

(Continued from Page 460)

1946, to December 31, 1946, with $385,000 disbursed by MMS for medical care of veterans.

Awards Voted

Approved were the recommendations of the Committee on Awards that Award Number III be voted to the Michigan Society for Crippled Children and Disabled Adults and to Dr. Charles F. Kettering for outstanding contributions in the cause of health, and that Award Number II be voted to Mr. Emmet Richards, President, and Mr. Percy Angove, Executive Director, of the Michigan Society for Crippled Children and Disabled Adults for their outstanding contributions to the cause of health.

Elections

L. Fernald Foster, M.D., Bay City, was re-elected Secretary, A. S. Brunk, M.D., Detroit, was re-elected Treasurer, and Wilfrid Haughey, M.D., Battle Creek, was re-elected Editor for the coming year. Mr. Wm. J. Burns was re-appointed Executive Secretary.

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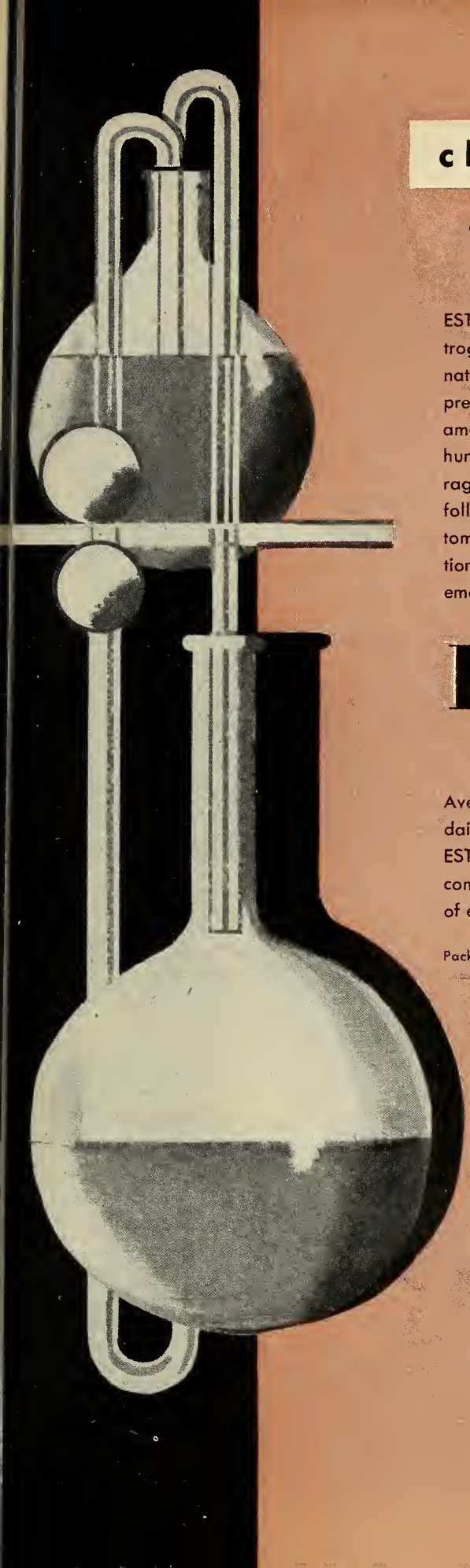

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. . . and as a sequel to the control of subjective symptoms, there is the emotional uplift or feeling of well-being which is so frequently reported by patients on "Premarin" therapy. "Premarin" has proved to be a valuable therapeutic medium for the management of the menopause and other manifestations of estrogenic deficiency.

To permit flexibility of dosage and enable the physician to fit estrogenic therapy to the particular needs of the patient, "Premarin" is supplied in two potencies — tablets of 1.25 mg. and 0.625 mg. Also available in liquid form, containing 0.625 mg. in each 4 cc. (1 teaspoonful).

*Although the principal estrogen in "Premarin" is sodium estrone sulfate, it also contains other equine estrogens . . . estradial, equilin, equilenin, hippulin . . . which are also present as water soluble sulfates. The water solubility of conjugated estrogens (equine) assures rapid absorption from the gastrointestinal tract.

CONJUGATED ESTROGENS (equine) **"Premarin"®***

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You and Your Business

WILL YOUR NAME BE IN THE MSMS ROSTER?

The Roster Number of THE JOURNAL (July, 1947) will go to press June 10.

The Roster will include the names of all physicians, members of the Michigan State Medical Society, with 1947 dues and assessments paid on or before June 10.

Be sure your name is in the Directory Number. If you have not already done so, contact the Secretary of your County Medical Society today.

* * *

INCREASE IN V.A. HOSPITALS

During 1946, Veterans Administration increased the number of its hospitals from 97 to 122. This represents a 23 per cent increase in beds available, from 79,450 to 97,772. V.A. reports a total of 458,749 admissions of veteran-patients to V.A. and non-V.A. hospitals during 1946, an increase of 61.3 per cent over 1945. The greatest number of admissions (83 per cent of the total) were general medical and surgical patients. V.A. expects to operate more than 200 hospitals, eventually, in order to handle the anticipated load of veteran-patients.

* * *

BENIGN AND MALIGNANT TUMORS

R. S. Sykes, D.D.S., of Muir, Michigan, has contributed $500 to the Michigan State Medical Society "to be used for instruction of doctors in the difference between non-pathological swellings and true sarcoma or cancer."

The Michigan State Medical Society has accepted Dr. Sykes' generous gift and has instructed that the fund be used during a five-year period to provide a lecturer at the Annual Session of the Michigan State Medical Society as well as at the Michigan Postgraduate Clinical Institute to speak on the subject "The Differential Diagnosis of Benign and Malignant Tumors."

* * *

MICHIGAN MEDICAL SERVICE

Taking a new approach toward explanation of Michigan Medical Service, its aims and its veterans' care program, officials of MMS entertained "the person who sees the patient first" at a luncheon April 15 at the Pantlind Hotel in Grand Rapids.

One hundred thirty doctors' nurses or secretaries, representing 150 Grand Rapids physicians, attended the luncheon and heard Jay C. Ketchum, executive vice president of Michigan Medical Service, trace the operation of MMS since its beginning in 1939 and outline the purposes of the organization.

Gordon Goodrich, assistant director of MMS, explained the veterans' care program, pointing out the necessity for the doctor always to "have prior authorization from the Veterans Administration before the veteran is treated or examined except in extreme emergencies."

An explanation of Michigan Hospital Service, companion organization to Michigan Medical Service, was given by James Foster, manager of MHS district offices.

William A. Hyland, M.D., president of the Michigan State Medical Society, welcomed the guests on behalf of the MSMS, and Kenneth Trim, MMS field representative, acted as toastmaster for the occasion.

* * *

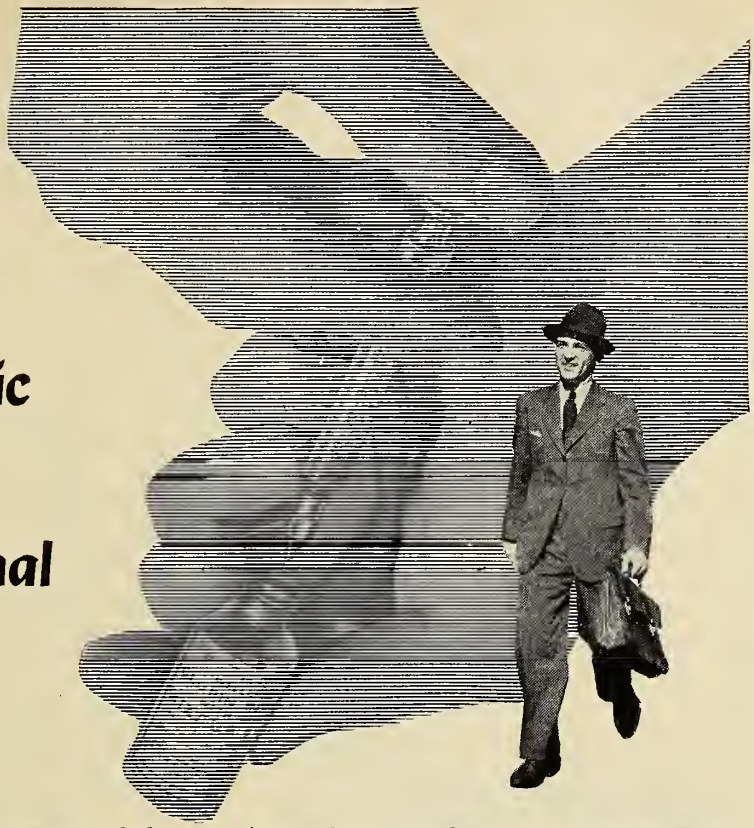
SPECIAL MEMBERSHIPS IN MSMS

The MSMS House of Delegates, in September, 1946, adopted a resolution instructing that a Committee of the House of Delegates be appointed to handle all recommendations for special memberships. It instructed that such resolutions be given the Chairman of this Committee prior to the first meeting of the Annual Session of the House of Delegates, for presentation *in toto* by the Chairman to the House of Delegates, to conserve the time of the House.

Delegates from the various county medical societies are requested, therefore, to refer all recommendations for Emeritus, Retired, Honorary, Associate, et cetera, memberships to the Secretary of the House of Delegates who in turn will present same, *in toto,* to the Chairman of the Special Committee on Special Memberships.

(Continued on Page 502)

to convert the diabetic into a more normal person



"The ideal in therapy...is to convert the diabetic into a normal person."[1] While certain restrictions must always be imposed, many patients can be controlled through diet alone so as to dislocate their normal habits as little as possible. In those cases where insulin therapy is also required, control may often be attained with but *one daily injection* of 'Wellcome' Globin Insulin with Zinc. Its intermediate action is adaptable to the needs of most mild and many moderately severe cases and adequate control can usually be achieved in three clear-cut steps:

1. *Stabilize the patient* as well as possible on a diet of the desired caloric content. Give a single dose of 15 or 20 units of 'Wellcome' Globin Insulin 30 minutes or more before breakfast.

2. *Adjustment to 24-hour control:* Gradually adjust the Globin Insulin dosage to provide 24-hour control as evidenced by a fasting blood sugar level of less than 150 mgm. or sugar-free urine in the fasting sample.

3. *Adjustment of diet:* Simultaneously adjust the carbohydrate distribution of the diet to balance insulin activity. Initially this may be 2/10 (breakfast), 4/10 (lunch), and 4/10 (supper). Any tendency toward mid-afternoon hypoglycemia may usually be offset by giving 10 to 20 grams of carbohydrate between 3 and 4 p.m. The final adjustment of carbohydrate distribution may be based on fractional urinalyses.

Systematic attention to these details will make possible adequate control of most mild and many moderately severe cases of diabetes with a *single daily injection of 'Wellcome' Globin Insulin with Zinc.*

'Wellcome' Globin Insulin with Zinc is a clear solution, comparable to regular insulin in its freedom from allergenic properties. Available in 40 and 80 units per cc., vials of 10 cc. Accepted by the Council on Pharmacy and Chemistry, American Medical Association. Developed in The Wellcome Research Laboratories, Tuckahoe, New York. U.S. Patent No. 2,161,198. LITERATURE ON REQUEST.

'Wellcome' Trademark Registered

1. Bauman, L.: Bull. New Eng. M. Center 5:17 (Feb.) 1943.

'WELLCOME' Globin Insulin WITH ZINC

BURROUGHS WELLCOME & CO. (U.S.A.) INC., 9 & 11 EAST 41ST STREET, NEW YORK 17, N.Y.

(Continued from Page 500)

WELCOME, DOCTOR!

The Michigan State Medical Society is happy to welcome the following newly elected members reported between February 15 and March 31, 1947, from the indicated component county medical societies:

Allegan County
K. C. Miller, M.D., Saugatuck

Berrien County
Harold Bjork, M.D., St. Joseph
G. T. Fattic, M.D., Niles
B. B. King, M.D., Benton Harbor

Branch County
R. M. Leitch, M.D., Union City

Calhoun County
Donald J. Pearson, M.D., Battle Creek
Frank W. Schwarz, M.D., Fort Custer

Clinton County
Charles S. Miller, M.D., Fowler

Grand Traverse-Leelanau-Benzie
Donald Pike, M.D., Traverse City

Huron County
Arno W. Weiss, M.D., Kinde

Kent County
Howard G. Benjamin, M.D., Grand Rapids
Melvin J. Freiswyk, M.D., Grand Rapids
Glenn W. House, M.D., Grand Rapids
Leonard Rosenzweig, M.D., Grand Rapids
Frank D. Thompson, M.D., Grand Rapids
Paul A. Van Pernis, M.D., Grand Rapids
H. Everett Van Reken, M.D., Sparta

Lenawee County
H. C. Huntley, M.D., Adrian

Mason County
J. C. Slaybaugh, M.D., Ludington

Marquette-Alger
R. C. Harsh, M.D., Marquette

Menominee County
J. M. Schroeder, M.D., Menominee

Monroe County
S. Newton Kelso, M.D., Ida

Northern Michigan
Lawrence E. Grate, M.D., Charlevois
Julien C. Kennedy, M.D., Cheboygan

Ottawa County
C. Dale Barrett, M.D., Grand Haven

Saginaw County
Kenneth C. Ling, M.D., Hemlock
Oscar A. Nelson, M.D., Saginaw

St. Clair County
W. S. Bowden, M.D., Marine City
Richard W. Hill, M.D., Yale
James Lauridsen, M.D., Port Huron

Washtenaw County
A. Waite Bohne, M.D., Ann Arbor
Wm. M. Brownlee, M.D., Ann Arbor
Alexander Gotz, M.D., Ann Arbor
Scott T. Harris, M.D., Ypsilanti
John C. Slaughter, M.D., Ann Arbor
Walworth R. Slenger, M.D., Ypsilanti
Daniel C. Thomson, M.D., Ann Arbor

Wayne County
Ira Avrin, M.D., Detroit
John H. Bailey, M.D., Detroit
Robert A. Brown, M.D., Detroit
Ensign Clyde, M.D., Ann Arbor
Maurice Croll, M.D., Detroit
Richard S. Donovan, M.D., Detroit
Wm. G. Fenner, M.D., Detroit
Wm. J. Fulton, M.D., Detroit
Fred G. Hicks, M.D., Dearborn
Edward A. Hoffman, M.D., Detroit
Harry Y. Hoffman, M.D., Detroit
Herbert Iwata, M.D., Detroit
O. Henry Jenton, M.D., Detroit
Robert C. Jeremias, M.D., Detroit
Malcolm J. Kelson, M.D., Detroit
John C. Kretzschmar, M.D., Detroit
M. Paul Mains, M.D., Detroit
Millard R. Marshall, M.D., Detroit
Peter A. Martin, M.D., Detroit
Richard D. Martin, M.D., Detroit
Elmer B. Miller, M.D., Detroit
Charles Moulton, M.D., Detroit
Wm. C. Noble, M.D., Ecorse
Arthur Northrop, Jr., M.D., Detroit
Robert H. Rupp, M.D., Ferndale
James W. Sinclair, M.D., Detroit
Howard P. Staub, M.D., Detroit
H. Saul Sugar, M.D., Detroit
Raymond H. Suwinski, M.D., Detroit
Robert G. Swanson, M.D., Detroit
Donald Sweeny, Jr., M.D., Detroit
Frank J. Szladek, M.D., Wyandotte
E. M. Wakeman, M.D., Dearborn
Stuart C. Wilson, M.D., Detroit
Charles Wright, M.D., Detroit

Have You Made Your

HOTEL RESERVATIONS?

MICHIGAN STATE MEDICAL SOCIETY

82nd Annual Session

Grand Rapids, September 23-24-25-26, 1947

The reservation blank below is for your convenience in making your hotel reservations in Grand Rapids. Please send your application to J. W. Logie, M.D., Chairman of Housing Committee, c/o Pantlind Hotel, Grand Rapids, Michigan. Mailing your application now will be of material assistance in securing hotel accommodations.

As very few singles are available, registrants are requested to co-operate with the Housing Committee by sharing a room with another registrant.

J. W. Logie, M.D., Chairman, Housing Committee,
Michigan State Medical Society Annual Session,
c/o Pantlind Hotel, Grand Rapids, Michigan.
Please make hotel reservation(s) as indicated below:

.....Single Room(s)
.....Double Room(s) for .....persons
.....Twin Bedded Room(s) for ....persons
Arriving September .....hour.....A.M.....P.M.
Leaving September .....hour.....A.M.....P.M.
(Names and addresses of all applicants including person making reservation).

Name	Address	City	State
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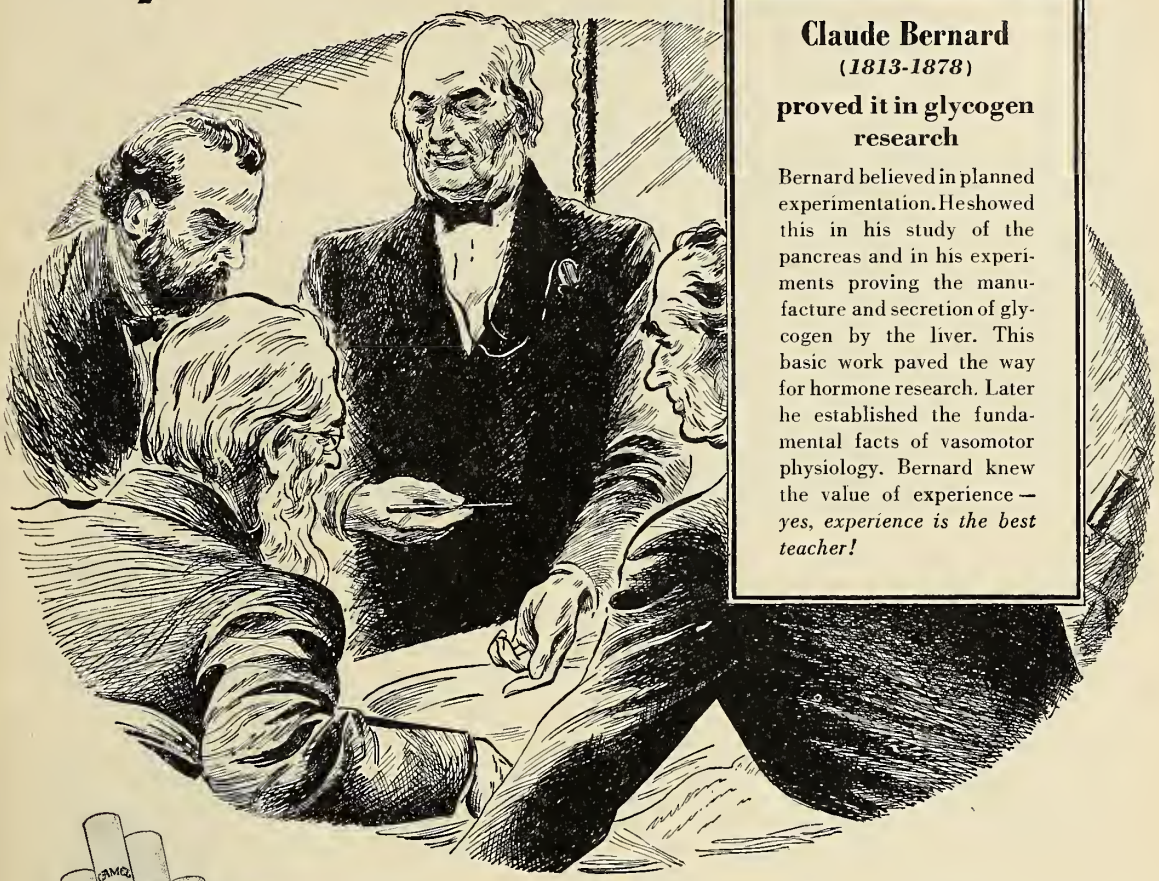
.....	.....	.....	.....

Date ..... Signature .....
Address ..... City.....

Experience is the Best Teacher



Claude Bernard
(1813-1878)
proved it in glycogen research

Bernard believed in planned experimentation. He showed this in his study of the pancreas and in his experiments proving the manufacture and secretion of glycogen by the liver. This basic work paved the way for hormone research. Later he established the fundamental facts of vasomotor physiology. Bernard knew the value of experience — *yes, experience is the best teacher!*

Yes, and experience is the best teacher in smoking too!

THAT wartime cigarette shortage was a real experience to smokers. Millions of people smoked more different brands than they would normally try in a lifetime. And out of the comparisons of that experience so many more smokers came to prefer Camels that today more people are smoking Camels than ever before.

We don't tamper with Camel quality. Only choice tobaccos, properly aged, and blended in the time-honored Camel way, are used in Camels.

According to a recent Nationwide survey:

MORE DOCTORS SMOKE CAMELS

than any other cigarette

R. J. Reynolds Tobacco Co., Winston-Salem, N. C.

National Health Act of 1947

Senate Bill 545

Summary Prepared by C. Rufus Rorem, Executive Secretary,
Hospital Council of Philadelphia,
Philadelphia, Pennsylvania

This Bill was introduced by Senator Robert A. Taft (for himself, Mr. Ball, Mr. Donnell, and Mr. Smith), February 10, 1947, and has been referred to the Committee on Labor and Public Welfare.

I. Introduction

A. The Act is cited as the "National Health Act of 1947" (Section 1)

B. *Preliminary Statement* (Section 2)

1. The bill calls attention to : (a) the *widely scattered* health and medical functions through the many agencies of the federal government; (b) the *inadequacies* of public health and medical and dental *services* in the United States.
2. The bill declares that it is the established policy of the United States:
   (a) *to aid the various states* through consulting services and grants-in-aid to make available medical, hospital, dental, and public health services to every individual, regardless of race, creed, or color.
   (b) *"to make provision for voluntary deductions from the salary of Federal employes* of premiums directed by them to be paid to *voluntary, non-profit health insurance funds."*

II. National Health Agency (Title I)

A. *The Agency and the Administrator* (Section 101)
There is established a new and independent *National Health Agency,* to be administered by a full-time *National Health Administrator* to be appointed by the President at a salary of $15,000 per annum. The Administrator must be a licensed doctor of medicine "who is outstanding in the field of medicine."

B. *Purpose of the Agency* (Section 102)
To promote the general welfare by aiding and fostering progress in the field of health and centralizing all Federal government agencies concerned with health.

C. *Duties of the Agency* (Section 102)

1. To encourage the development of health services and facilities
2. To co-operate with federal, state and private agencies
3. To collect and analyze statistics, etc.
4. To make studies of policies and methods
5. To perform other specific duties as directed by the Congress

D. *Responsibility for Federal Government Activities* (Section 102)

1. *Administration of funds* appropriated as grants-in-aid to the states *for medical, dental and hospital care,* hospital facilities, etc.
2. *Administration of Hospital Survey and Construction Act* (Public Law 725)
3. Prevention of disease through various public health activities in the field of sanitation
4. Promotion of maternal, prenatal and child care
5. Regulation of food, drugs and cosmetics
6. Training and rehabilitation of vocationally handicapped persons
7. Handling of other matters pertaining to the national health

E. *Duties Transferred from other Federal Agencies* (Section 103)

1. No activities in the field of health would be transferred from the Army, Navy or Veterans Administration.
2. The Agency would take over the duties, personnel, funds, properties and records of:
   (a) The Federal hospitals in Washington, D. C.
   (b) The food and Drug Administration
   (c) The Children's Bureau
   (d) The Division of Health Studies in the Bureau of Research and Statistics of the Social Security Administration

F. *Organization of the Agency* (Section 104)

1. *The Agency will be composed of the following units:*
   (a) Office of the Administrator
   (b) The Public Health Service (Surgeon General)
   (c) Office of Medical and Hospital Care (Director an M.D.)
   (d) Office of Dental Care Services (Director a D.D.S.)
   (e) The Office of Maternal and Child Health
   (f) The Office of Health Statistics
   (g) The Food and Drug Administration
   (h) Others as deemed necessary
2. *Appointment of executive officers*
   (a) Details of the Food and Drug Administration remain unchanged

(Continued on Page 506)

There have been several analyses of the S. 545, one by the A.M.A., another in our editorial in April, and this one by Mr. Rorem. This is complete and concise, and we are glad to give it space for the information of our readers.

FIGURE 1 — Patient — thin type of build with beginning faulty body mechanics. The Camp adjustment provides a more stable pelvis, allowing patient to "draw-in" the abdominal muscles thus gradually acquiring a gentle lumbar curve.

FIGURE 2 — Patient — intermediate type of build. Strain of lumbosacral joint predisposes to other strains. For protection of the joints in the lumbar region from recurrent strain and also as an aid in relieving the pain of acute conditions, Camp lumbosacral supports have proved effective.

In the Conservative Treatment of

The Lumbosacral and Lower Lumbar Regions

CAMP SUPPORTS offer advantages

• • • Give firm support to the low back; the support is easily intensified by re-inforcement with pliable steels or the Camp Spinal Brace.

• • • Afford a more stable pelvis to receive the superincumbent load.

• • • Allow freedom for contraction of abdominal muscles under the support in instances of increased lumbar curve (fig. 1).

• • • Are removed easily for prescribed exercises and other physical procedures prescribed by physiatrist or physician.

S. H. CAMP AND COMPANY • JACKSON, MICHIGAN

World's Largest Manufacturers of Scientific Supports

Offices in New York • Chicago • Windsor, Ontario • London, England

(Continued from Page 504)

(b) The Surgeon General of the Public Health Service will continue to be appointed by the President.

(c) Other heads of the constituent units are to be appointed by the "Administrator."

(d) The head of the Office of Maternal and Child Health Services (qualifications not stated) shall be assisted by an Advisory Council of eight persons (appointed by the administrator) three of whom shall be physicians who are specialists in obstetrics or pediatrics.

3. The Administrator is directed to make a *study of the organization* and staff of the Agency, and to make recommendations within six months on such matters as salaries, the commissioned corps of the Public Health Service, and the desirability of establishing an Office of Health and Medical Research.

III. Special Cancer Appropriation (Section 203)

$10,000,000 is provided to enable the Surgeon General to develop a program for prevention and control of Cancer through grants-in-aid and other methods in co-operation with state and local government health agencies.

IV. General Medical Service for Families and Individuals of Low Incomes (Title VII)

A. *Medical Care Survey* (Section 701-703)

$3,000,000 is authorized for grants-in-aid to States for surveys of medical and hospital care needs, to be allotted on a matching basis ($1.00 federal for $2.00 state) to States according to population, up to the total appropriation. Minimum per State is $10.00.

The requirements to qualify for survey grants-in-aid, are essentially the same as outlined in Section 712.

B. *Medical Care Services*

1. *Appropriations* (Section 711)

An annual appropriation of $200,000,000 is provided for five years, to assist the states to *provide general health, hospital and medical services for families and individuals with low incomes.* The sums appropriated will be used for making payments to the states which have submitted "Plans and had them approved by the Director of Medical and Hospital Care Service."

2. *Standards for a State plan which may qualify for grants-in-aid* (Section 712)

(a) Designation of a *single state agency* to handle the program.

(b) Designation by the Governor of a State *medical and hospital care advisory council* which will include representatives of nongovernment and state agencies concerned with the administration or utilization of health or medical services.

(c) Satisfactory *evidence of authority.*

(d) The program must be calculated to provide (within 5 years)

(1) hospital, surgical and medical *services in hospitals, clinics, or similar institutions* for all those families and individuals in the state having insufficient income to pay the whole cost of such service.

(2) periodic physical examinations for all children in elementary or secondary schools in the state.

(Approved hospital, surgical and medical service programs may provide for furnishing care to families and individuals through *payments by the State to non-profit voluntary health, medical or hospital insurance funds,* "as premiums, partial premiums, reimbursement of expenses, or otherwise."

State payments may be made directly to *local government or voluntary* non-profit health programs, *also to physicians* practicing in areas which, without such payments, would be unable to provide sufficient income to attract a practicing physician).

(e) *Financial participation* by the State.

(f) Statement of the priority of various proposals in the plan.

(g) Completion of a state-wide inventory of health facilities.

(h) Provision for reports and periodic review.

3. *Basis of Grants-in-Aid* (Section 713)

There would be varying ratios of grants-in-aid by the Federal government (based on each State's population and tax-paying ability) not to exceed two-thirds or to be less than one-fourth of the total expenditures by a State plan. Agencies administering the State plans will submit complete reports to the Director. There is provision for appeals which may be made with respect to rulings and regulations.

4. *National Medical Care Council* (Section 715)

This is an advisory body with whom the Director shall "consult" in administering the Medical and Hospital Care Program.

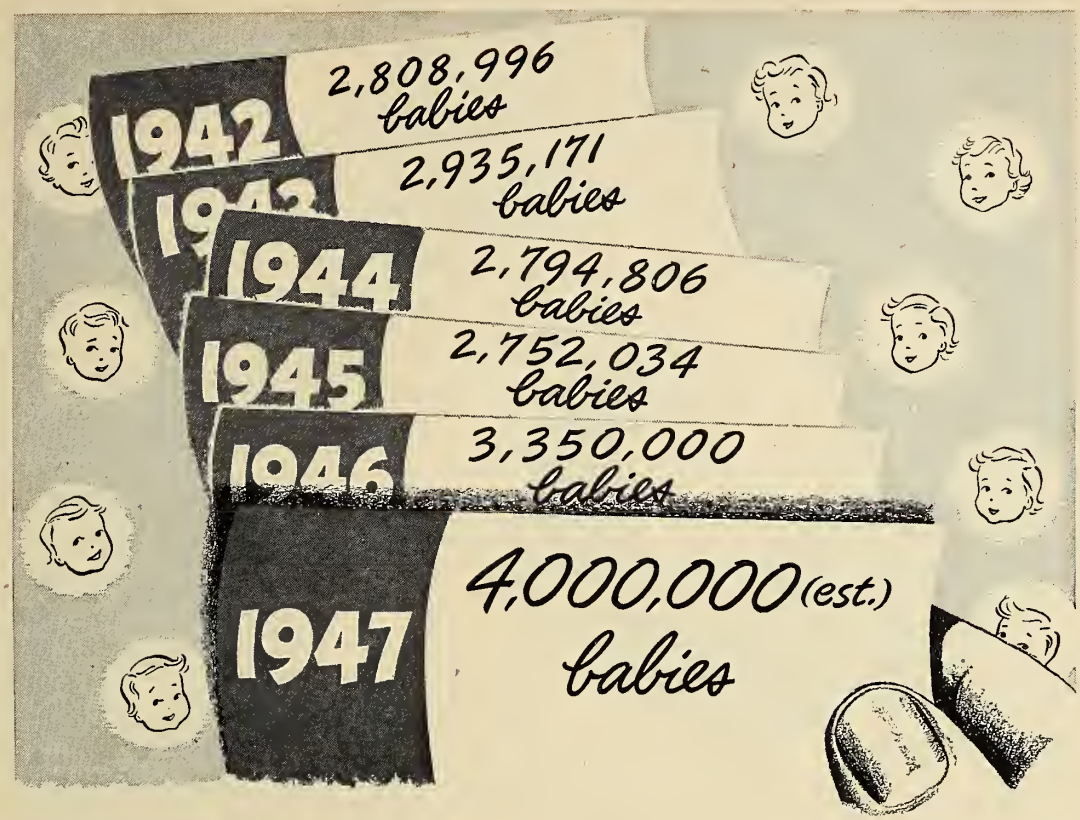
The Director is ex-officio chairman, and eight other members (five of whom must be specialists in the field of medical and hospital care, and four doctors of medicine are to be appointed by the Administrator.

The Director is authorized to utilize the services and facilities of any executive department or agency.

V. Dental Health Services (Title VIII)

This portion covers dental health services for school children and provides for increasing appropriations as grants-in-aid from the Federal government: $1,000,000 for surveys and annual amounts ranging from $8,000,000 for the first year to $20,000,000 at the end of five years. The requirements for grants-in-aid for dental programs are similar to those for medical and hospital care and for school inspection.

(Continued on Page 605)



Borden's prescription specialties are flexibly adaptable to cope effectively with the sharply increased number of your infant feeding problems.

BIOLAC—a complete infant formula (only vitamin C supplementation needed) for infants deprived of mother's milk.

DRYCO—a powdered, high-protein, low-fat, moderate carbohydrate milk food ideally suited for all formulas.

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MULL-SOY—a hypo-allergenic emulsified soy food for infants and adults allergic to milk proteins. The 1:1 standard dilution approximates cow's milk in fat, protein, carbohydrate and mineral content.

KLIM—a spray-dried whole milk with soft curd properties essential in infant feeding and special diets. Particularly valuable when availability or safety of fresh milk is uncertain.

BORDEN 1857 ACCEPTED AMERICAN MEDICAL ASSN. SINCE 1857 THE GREATEST NAME IN MILK

Borden prescription products are available at all drug stores. Complete professional information may be obtained on request.

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Michigan Postgraduate Clinical Institute

The registration at the 1947 Institute in Detroit totalled 1,293. The breakdown follows:

Doctors of Medicine	1,082
Guests and Exhibitors	211
TOTAL	1,293

A total of 113 out-of-Michigan Doctors of Medicine came from nine states, as follows: 47 from Ontario, 40 from Ohio, 12 from Indiana, 8 from Wisconsin, 2 from Illinois, and 1 each from California, Iowa, Louisiana and New York.

A total of 9,317 lines of publicity appeared in Detroit and Michigan newspapers in connection with the Michigan Postgraduate Clinical Institute of 1947!

UNSOLICITED COMMENTS RE THE MICHIGAN POSTGRADUATE CLINICAL INSTITUTE

R. A. Fargher, M.D., of LaPorte, Indiana: "I am writing to tell you how much we enjoyed and how much benefit we received from our visit to Detroit this past week. The two of us from here who attended felt that we were greatly repaid in information for the effort we put forth in coming. It is my contention that we men in general practice do not have enough such opportunities to keep up on things; I hope there will be a Michigan Postgraduate Clinical Institute to attend next year."

D. H. Bruns, M.D., of Milwaukee, Wisconsin: "I am grateful for having been privileged to participate in the first annual Michigan Postgraduate Clinical Institute. Both the scientific and practical presentation of chapters of nearly every field of medicine was inspiring. If permitted, I certainly will attend your next year's Institute."

John M. Dorsey, M.D., Detroit: "The responsibility of being of service in our great Michigan Postgraduate Clinical Institute was very much of the nature of a fine privilege. May I take this occasion to thank you and to advise that the opportunity to be able to be a little helpful pleased me. I wish you continued success with the Michigan Postgraduate Clinical Institute."

F. E. Carrel, M.D., of Frankfort, Indiana: "Believe me, it was refreshing to hear those twenty-minute lectures without listening to history and statistics. The many things learned have already had numerous application with the result of more satisfied patients."

B. B. Backley, M.D., of Lakewood, Ohio: "I enjoyed the Michigan Postgraduate Clinical Institute very much and am looking forward to the 1948 Institute. I wish to express my thanks for your inviting to the first, recent Institute. I shall try to promote more interest among the fraternity here to attend the second session next March.

Raymond T. Saxen, M.D., Hicksville, Ohio: "The 1947 Michigan Postgraduate Clinical Institute was very highly practical and instructive to a general practitioner like myself. It is indeed a pleasure to attend a session in which there is a departure from the papers on rare and infrequent conditions. I am very hopeful that meetings of this caliber will be permanent annual affairs."

James L. Henderson, M.D., Detroit: "I consider the Michigan Postgraduate Clinical Institute the most concise and generally beneficial postgraduate study offered to Michigan doctors in my 33 years of practice."

R. A. Wagner of Smith, Kline & French Laboratories, Philadelphia: "Our representatives who attended the first annual Michigan Postgraduate Clinical Institute told me of the success of it—of the physicians' interest in the technical exhibits and of the splendid co-operation of the convention management. We shall indeed look forward to attending again next year."

J. A. Lutz of W. B. Saunders Company, Philadelphia: "Congratulations on the success of the first annual Michigan Postgraduate Clinical Institute. Of course we want to attend the 1948 Institute and all future Institutes, so send us an invitation every year."

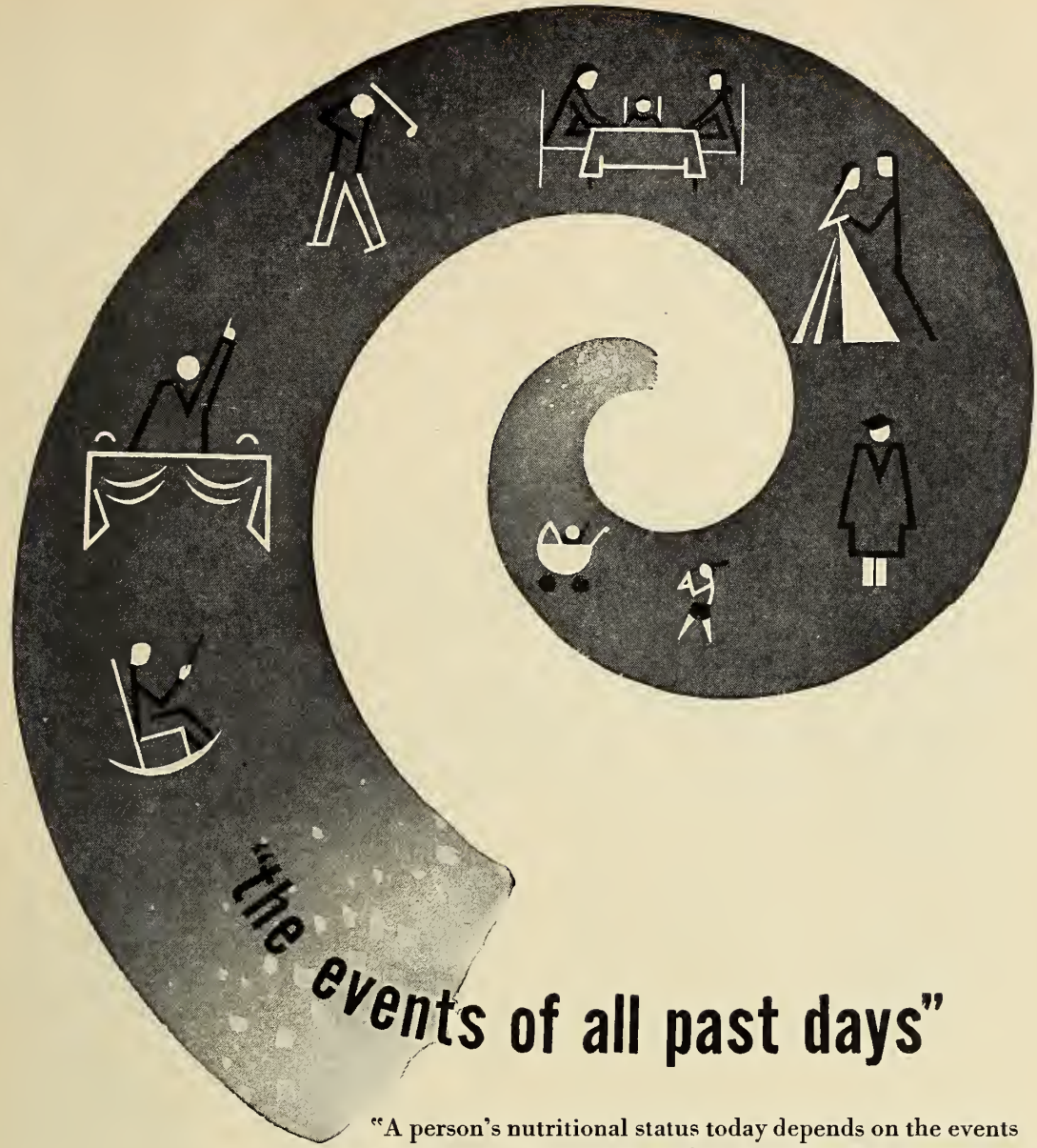
R. O. Johnson of Farnsworth Laboratories, Chicago: "We are very happy for having attended the Michigan Postgraduate Clinical Institute. You made a fine job of it. Thank you for your splendid co-operation. I am looking forward to the 1948 Institute and we want to be entered now as a participant.

R. V. Oosting of Medical Arts Surgical Supply Company, Grand Rapids: "I want to take this opportunity to congratulate you on the very fine Michigan Postgraduate Clinical Institute so ably conducted in Detroit. I would like to make reservation for our attendance next year."

J. W. Colen of J. B. Lippincott Company, Philadelphia: "It is with a great deal of pleasure, that I write you advising we consider the Michigan Postgraduate Clinical Institute, recently held in Detroit, as a very successful meeting."

Morton Hack of Hack Shoe Company, Detroit: "The Michigan Postgraduate Clinical Institute provides an excellent opportunity for reiterating our so-often ex-

(Continued on Page 512)



"the events of all past days"

"A person's nutritional status today depends on the events of all past days."[1] Slight deficiencies should not be ignored "as if they were without effect," for "partially, indeed slightly deficient diets eaten regularly and periodically over many years have their consequences."[1] Such nutritional delinquency often takes its greatest toll under the stress of illness, surgery, pregnancy, lactation, or accident. For depleted tissues, Upjohn vitamins provide a wide range of dosage forms for therapy or supplementation, in preparations adapted to oral and parenteral administration in the practice of medicine and surgery.

1 National Research Council Bull. No. 109. 1943, pp. 18-21.

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FINE PHARMACEUTICALS SINCE 1886

UPJOHN VITAMINS

(Continued from Page 510)

pressed appreciation for your many courtesies over the years of our association. The Hack Clan rated the recent Institute as 'tops.' "

RECORD OF ATTENDANCE

Postgraduate credits: one unit of credit for each day of postgraduate attendance was given every member of the Michigan State Medical Society registering at the first annual Michigan Postgraduate Clinical Institute. The following MSMS members registered on March 12 (the registrations of March 13 and March 14 will appear in a subsequent Number of JMSMS).

Registration—March 12

Vernon C. Abbott, Pontiac; James R. Adams, Dearborn; E. R. Addison, Crystal Falls; Sidney L. Adelson, Detroit; Alfred L. Aldrich, Ithaca; Allen Alexander, Detroit; Herbert C. Allison, Gross Pointe; Sam Alpiner, Detroit; Abraham Altshuler, Detroit; Emil Amberg, Detroit; Florence Ames, Monroe; Walter L. Anderson, Detroit; F. T. Andrews, Bay City; Howard B. Appelman, Detroit; Robt. J. Armstrong, Kalamazoo; Harry Arnkoff, Pontiac; Emilie Arnold-Clarke, Lansing; R. J. Arrington, Detroit; S. R. Ashe, Detroit; A. U. Axelson, Detroit.

Walter F. Bach, Detroit; M. E. Bachman, Detroit; Vinton A. Bacon, Detroit; Harry E. Bagley, Dearborn; William A. Bailey, Detroit; William J. Bailey, Detroit; Clarence Baker, Detroit; George M. Baker; Parma; Robert H. Baker, Pontiac; Joseph A. Bakst, Detroit; Harry Balberur, Detroit; Charles W. Balser, Detroit; Lewis R. Barak, Detroit; Harry A. Barbour, Mayville; R. H. Baribeau, Battle Creek; Oscar L. Barland, Detroit; S. E. Barnett, Detroit; Chas. J. Barone, Detroit; Winona Barrows, Royal Oak; William A. Barss, Detroit; F. W. Bartholic, Homer; F. W. Baske, Flint; Paul H. Bassow, Ann Arbor; Ernest W. Bauer, Hazel Park; L. E. Bauer, Detroit; Colin Beaton, Detroit; W. G. Beattie, Ferndale; Abraham Becke, Detroit; L. E. Beeuwkes, Dearborn; Warren F. Belknap, Royal Oak; Wm. M. Bell, Detroit; George W. Bennett, Elsie; S. A. Bennett, Detroit; Z. B. Bennett, Detroit; John C. Benson, Flint; John C. Benson, ,Jr., Flint; Virginia M. Benson, Detroit; Frederick Bentley, Plymouth; Richard H. Berg, Oxford; H. L. Bergo, Detroit; Robert Berman, Detroit; Albert E. Bernstein, Detroit; E. A. Bicknell, Detroit; G. C. Bishop, Almont; Kenneth E. Blain, Detroit; E. W. Blanchard, Deckerville; D. C. Bloemendaal, Zeeland; P. W. Bloxsom, Grand Rapids; Arthur F. Boell, Detroit; A. T. Bonathan, Flint; A. M. Bookstein, Detroit; Carl F. Boothby, Hartford; P. R. Boothby, Lawrence; T. A. Boutrous, Detroit; Fred C. Brace, Grand Rapids; Andrew H. Bracken, Dearborn; H. A. Brady, River Rouge; F. W. Bramigk, Detroit; Walter A. Briegel, Detroit; William Bromme, Detroit; C. W. Brooks, Detroit; John Bryce, Detroit; W. Paul Buchanan, Detroit; John D. Buck, Detroit; F. G. Buesser, Detroit; F. L. Bull, Sparta; Bert M. Bullington, Saginaw; J. G. Burdick, Allegan; W. M. Burling, Grand Rapids; Julius N. Burnstine, Detroit; Harry J. Butler, Detroit; G. M. Byington, Detroit.

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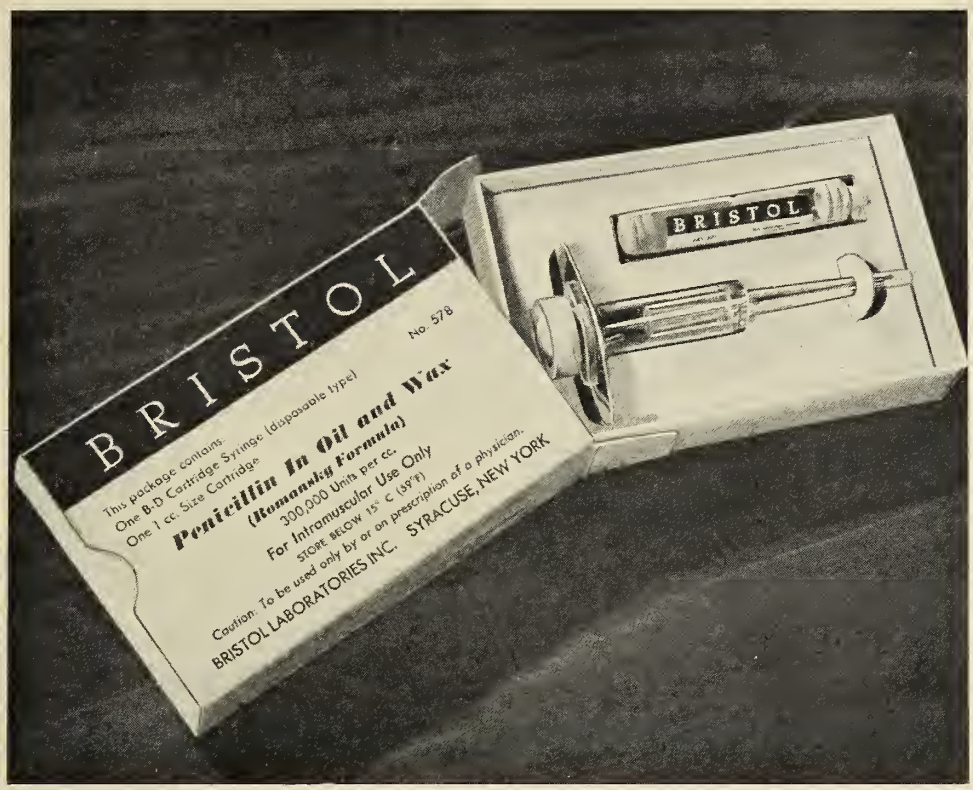

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(Balance of registrations in subsequent issues)

Postgraduate Continuation Courses

Wayne University College of Medicine, Detroit, announces two Postgraduate Continuation Courses for the quarter beginning June 9, 1947. A Medical X-Ray Conference at Receiving Hospital will be held Tuesdays from 11:00 a.m. to 12 noon, fee $15.00; a Medical Pathological Conference, also at Receiving Hospital, will be held Fridays from 11:00 a.m. to 12 noon, fee $15.00. Register with the Postgraduate Medical Education Secretary, 1512 St. Antoine, Detroit, any time before June 9.

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The JOURNAL

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VOLUME 46 MAY, 1947 NUMBER 5

Serodiagnosis of Syphilis

Recent Advances

By Charles R. Rein, M.D.
New York, New York

Practicing physicians have had the problem of how to evaluate or interpret serologic reports obtained from the laboratory in determining the presence or absence of a syphilitic infection. Every physician has probably had patients with clinical syphilis in whom the serologic tests gave negative reactions, as well as nonsyphilitic patients with unexplained positive serologic reactions. Such discrepancies are to be expected, since it is well known that there are no true specific tests for syphilis. When Wassermann, Neisser and Bruck[42] developed the first serologic test for syphilis some forty years ago, they felt that they had devised a specific and a sensitive laboratory procedure for the diagnosis of syphilis. They considered their test specific because they employed a saline extract of *syphilitic* liver for the antigen. They thought it was adequately sensitive because positive reactions were obtained with the blood of many individuals with active clinical syphilis. It was, however, soon discovered that not only were these antigens nonspecific, but that alcoholic lipoid extracts obtained from normal tissue were more specific and more sensitive than the aqueous extracts of syphilitic tissues. Fortunately the combined efforts of research-minded serologists and clinicians have done much to improve those procedures which are employed today in the serodiagnosis of syphilis.

Considerable progress has been made in the laboratory, in the proper interpretation and the clinical application of these serologic procedures. I will briefly describe the improvement made in laboratory techniques and in materials employed.

Collecting Tubes.—The use of wet and nonsterile syringes in the collection of blood specimens rendered many of them unsatisfactory for serologic testing. The development of inexpensive dry and clean vacuum tubes for the collection and mailing of blood specimens has done a great deal to decrease the number of unsatisfactory specimens received by the laboratory. Sterility is not an absolute necessity when clotted bloods are shipped, since the clot seems to exert a bacteriostatic effect on the serum. It is important, however, that the collecting and mailing tubes be clean and dry.

Serum Preservatives.—In warm climates, clotted blood specimens become hemolyzed and may therefore become unsatisfactory for testing. Army facilities found it necessary to separate the serums from the clots to eliminate hemolysis. Frequently it was necessary to ship these serum specimens to distant laboratories, and it was sometimes quite difficult and often impossible to insure sterility in the collection and preparation of serum. During the several days it took for the specimens to reach the laboratory they became badly contaminated and unsatisfactory for testing. It was deemed necessary to find a suitable substance which would prevent this contamination and not interfere with serologic testing. Merthiolate answered this need. Merthiolate (sodium ethyl mer-

From the Skin and Cancer Unit of the New York Postgraduate Medical School and Hospital, Columbia University, Dr. George M. MacKee, Director; and the Division of Serology, Army Medical School, Army Medical Center, Washington, D. C.

Presented at the eighty-first annual session, Michigan State Medical Society, Detroit, Michigan, September 27, 1946.

curi thiosalicylate) is an excellent bacteriostatic and bactericidal agent for the preservation of serums, and for the past several years has been employed by the United States Public Health Service and other agencies for the preservation of serum and spinal fluid specimens intended for shipment over considerable distances. In the Division of Serology at the Army Medical School,[34] sera preserved with one mg. of merthiolate per millimeter have been used routinely with excellent results. The use of merthiolate as a preservative in army laboratories has markedly decreased the number of specimens rendered unsatisfactory for serologic testing because of bacterial contamination. During the past three years more than 20,000 merthiolated specimens have been received at the Division of Serology for special serologic studies, and less than 0.1 per cent were unsatisfactory for testing because of bacterial contamination.

Inactivation of Serum.—For many years it was believed that it was not necessary to heat or "inactivate" serums prior to testing with the various flocculation tests, and that such "inactivation" was only necessary to destroy the native complement present in fresh serums when tested with the complement-fixation procedures. Recent studies at the Army Medical School[37] have indicated that fresh syphilitic serums contain a thermolabile substance which inhibits or retards the aggregation of lipoidal antigens in flocculation reactions. Strongly positive serums would often give negative reactions when tested in the raw or unheated state. It was found that all serums had to be heated[36] before testing with complement-fixation or flocculation procedures. Serums heated for ten minutes at 56° C., for one minute at 69.5° C., and seven seconds at 100° C. (in boiling water) gave results that were practically identical with those obtained with serums heated for the routine thirty minutes at 56° C. The unnecessary prolongation of the heating period tends to destroy some of the reagin in the serum. The rapid preparation of serum in this manner is especially valuable as a time-saving factor where the rapid flocculation tests are used for the detection of syphilis in donors just prior to transfusion.

Antigens.—Considerable progress has been made in the improvement of the various lipoidal antigens. The isolation by Pangborn[26,27,29] of the substance cardiolipin from beef heart and the development of methods for the purification of lecithin[28] prepared from both heart and egg yolk promised to contribute much to the improvement of serodiagnostic tests for syphilis. Several investigators, Harris and Portnoy,[8] Harris, Rosenberg and Reidel,[9] Kline,[19] Brown,[2] the Maltaners[22] have described the preparation of cardiolipin antigens for use in the various complement-fixation, macro and microflocculation tests. At the Army Medical School, a cardiolipin antigen[33] was successfully adapted for use in a microflocculation slide test for the serodiagnosis of syphilis. The sensitivity of this test was higher than that obtained with the Kline diagnostic, Mazzini, Kahn and Kolmer tests. It was of interest to note that this increased sensitivity was obtained without any apparent increase in nonspecificity. In fact, the extraordinary specificity of the cardiolipin antigen in the presence of malarial infection was repeatedly demonstrated.

Preserved Sheep Blood.—One of the difficulties encountered in the performance of complement-fixation tests is in obtaining satisfactory sheep blood. The smaller hospital laboratories with no facilities for the raising of sheep have to obtain their supply from the slaughter house. Many times the red blood cell suspensions prepared from such sheep blood prove to be unsatisfactory. A preservation technique for maintaining uniformity in the properties of sheep cells would be a great laboratory convenience. It would be advantageous to employ preserving fluids which would maintain the properties of sheep blood over long periods and particularly during periods of transportation. Quantitative studies at the Army Medical School indicate that aseptic collection of sheep blood in modified Alsevers' solution[3] at ordinary temperatures and subsequent refrigeration permit the preservation of the blood for several months without the development of appreciable hemolysis or change in susceptibility to lysis by guinea pig complement and rabbit amboceptor. Blood collected in this fashion has been used for the past two years with complete satisfaction.

Spectrophotometer.—Accurate standardization of the hemolytic system in the complement-fixation tests has become of paramount importance in maintaining a constant level of sensitivity. To

this end the spectrophotometer has been adapted,[18] not only for quantitative titration of complement and amboceptor, and for the standardization of sheep cell suspensions, but also for the final readings of the tests themselves. The use of this instrument has been adapted for the complement-fixation test for syphilis as well as for complement-fixation tests employed in the serodiagnosis of other diseases, such as malaria and amebiasis.

Amboceptor.—The preparation of antisheep amboceptor with the elimination of rabbit shock has also proved advantageous to laboratories performing complement-fixation tests. The chief difficulty in preparing amboceptor has been the heavy loss of rabbits by shock, particularly following the injection of the second dose of cells. Furthermore, when whole cells are employed, the finished amboceptor may contain relatively large amounts of agglutinogens or precipitins, rendering it unsatisfactory for use. A method[38] was developed at the Army Medical School for the preparation of antisheep amboceptor utilizing the cell stroma instead of the packed washed cells. The stroma is prepared by specifically hemolyzing washed sheep cells with amboceptor and complement. During five years of use with over 500 animals, there have been no rabbit deaths due to shock. Satisfactory amboceptor has been produced in about ten days, and the titers are higher than those obtained by other methods.

Complement.—The majority of small laboratories do not have facilities for maintaining their own colony of guinea pigs which are necessary for their supply of guinea pig complement. Dried or lyophilized guinea pig serum has been used at the Army Medical School in various types of complement-fixation tests with excellent results. Dried guinea pig complement supplied to the Army Medical School had to meet the following requirements:

1. *Titer:* The exact hemolytic unit should be contained in no more than 0.45 ml. of a 1:30 dilution when titrated by the Kolmer method.
2. *Moisture content:* Should not exceed 1 per cent by weight.
3. *Hemoglobin content:* Should be minimal.
4. *Source of guinea pigs:* The serum should be obtained from normal healthy guinea pigs which have never been used for any other purpose.
5. *Preserving fluid:* Supplied with the dried product should contain 6 per cent sodium acetate and 2 per cent boric acid.

Several commercial concerns prepare dried guinea pig complement which meet the above requirements and give satisfactory results.

Serum Controls.—A positive and negative serum control should be included every time serologic examinations are made. This helps to insure the sensitivity and specificity of the test employed and tends to minimize the occurrence of technical errors. Unfortunately, many laboratories select a strongly positive serum for their control. Such controls are unsatisfactory for detecting a decrease or increase in the sensitivity of a serologic procedure, for if the sensitivity has been reduced or increased as much as 50 per cent, a strongly positive serum might still give a four-plus reaction. The use of weakly positive or partially positive serums would more readily detect a change in sensitivity due to technical errors or to deterioration of materials employed. If strongly positive serums are utilized, they should be subjected to serial dilutions and the test performed on each dilution. A reduction or increase in *titer* would indicate a change in sensitivity. The utilization of a strongly positive serum (quantitative control) or weakly positive serums (qualitative controls) is of utmost importance in controlling the sensitivity level of a serologic procedure.

There have been many more improvements such as the use of recalcified plasma instead of serums for serologic testing, the use of the 50 per cent hemolytic unit instead of 100 per cent end point of hemolysis in determining the degree of fixation of complement by specific antigen-antibody complex, the introduction of the new wetting agents for the proper washing of serologic glassware, the use of buffered solutions in preparing the antigen emulsions, complement and amboceptor dilutions and for diluting strongly positive serums for the various quantitative tests, the prevention of nonspecific and prezone reactions in the complement-fixation test with spinal fluid by the addition of egg albumen or normal serum to the complement, and the development of special procedures to differentiate between true and false positive reactions. Suffice to say that all of these advances have

helped considerably in the improvement of our serodiagnostic procedures.

Serologic Surveys

Together with the technical advances made, definite progress has also been made in the interpretation and clinical application of serodiagnostic procedures. Many modified methods of complement fixation and flocculation tests have been described and accepted during the past forty years. It must be understood that although these tests are identified by individual names they are not *unrelated* reactions. All depend on the same mechanism of combination of the syphilitic reagin with the lipoid antigen. Each serologist has attempted, however, by various means to make his test more sensitive, more specific, more constant or simpler in technical performance. Many have succeeded in one or more of these improvements. Others, however, have improved one factor at the expense of others, and as a rule their tests are soon discarded. Unfortunately, a new test sometimes falls into the hands of serologists and even practicing physicians before its efficiency has been proved, and considerable harm is done to unsuspecting patients before the tests are standardized or abolished. The basis for selection of suitable standard tests to be used in the serum diagnosis of syphilis has been the accumulated data, regarding the efficiency of the many tests evaluated in the various official serologic conferences. The United States Public Health Service, in collaboration with the American Society of Clinical Pathologists, has had a number of evaluation studies to appraise the various tests employed in this country. These studies have done a great deal to determine the unsatisfactory tests and to encourage the participating serologists to improve the specificity and sensitivity of their respective procedures. Criteria have been established for adequate specificity and sensitivity, and only tests conforming to these standards should be used for the routine serodiagnosis of syphilis. With increased sensitivity it has been possible to detect more syphilitic individuals *very early* and *much later* in the course of their infection.

Penicillin Therapy in Concomitantly Acquired Gonorrhea and Syphilis

With the introduction of penicillin, the physician now has at his disposal a therapeutic agent which is efficacious in the treatment of gonorrhea and syphilis. When penicillin was adopted by the Armed Forces as the standard treatment for gonorrheal infections, it was anticipated that a concomitantly acquired syphilitic infection would be masked by the penicillin, and many reports of this type have appeared in the literature. In most instances the patient acquired syphilis concomitantly with the gonorrheal infection. Promiscuous patients, however, may acquire syphilis immediately prior to or soon after becoming infected with gonorrhea. The amount of penicillin (usually 200,000 to 400,000 units) which is adequate for the cure of gonorrhea is definitely inadequate for the concomitant syphilitic infection. In such patients the following may occur:

Abort.—If the patient received penicillin very early in the course of the gonorrheal infection, and the syphilis is only of a few days' duration, that relatively small amount of penicillin may be sufficient to abort or cure the syphilitic infection. This has been corroborated by animal experiments where small amounts of penicillin administered a few days after infection were sufficient to effect a cure.

Mask—If the concomitant syphilitic infection is a few days older, the same amount of penicillin may prevent the appearance of the primary or secondary lesions. In such instances the only evidence of a syphilitic infection is the development of positive serologic tests for syphilis several weeks or months following treatment of the gonorrheal infection.

Delay.—In still older infections the penicillin therapy will tend to delay the appearance of the early cutaneous manifestations for several months after the disease has been acquired.

Some investigators[7,21] have observed the occurrence of chills, fever and malaise developing early in the course of penicillin therapy for gonorrheal patients who also have a syphilitic infection. They believe these symptoms indicate a Herxheimer reaction due to the rapid destruction of the spirochetes, the incidence and severity of the reactions depending upon the extent of the spirochetal invasion. It has been suggested that the following be done whenever penicillin therapy is instituted for gonorrheal infections: (1) thorough examination for any clinical evidence of syphilis and the performance of a serologic test

prior to the administration of therapy, (2) observations for the occurrence of chills, fever and malaise accompanying penicillin therapy, and (3) repeated clinical and serologic re-checks at monthly intervals for six months following therapy. If, at any time during this period there is any clinical or serologic evidence of syphilis, additional adequate penicillin therapy should be administered.

Serologic Response in Penicillin-Treated Syphilis

Physicians are often disappointed when serologic tests remain positive for several months following penicillin therapy for syphilis. There are, however, several factors which influence the length of time required to attain sero-negativity.

Stage of Disease.—The older the disease, the longer spirachetes are present and the longer it takes for the body cells to stop forming reagin. As a rule patients with secondary syphilis require more time to acquire sero-negativity than patients with sero-positive primary lesions.

Immunologic Response of Individual Patients.—Some patients with syphilis develop more antibodies or reagin than do others after the same type of stimulus. The former patients usually require more time to attain sero-negativity.

Serologic Titer.—As a rule, patients with high serologic titers at the onset of therapy may require more time than those with relatively low titers to attain sero-negativity.

Sensitivity of the Serologic Procedure.—The more sensitive the serologic test, the longer it will take to attain sero-negativity. When a serologic battery consisting of tests with varying sensitivities is employed, negative reactions may be obtained with the less sensitive tests long before the more sensitive tests become negative.

Type of Test.—Certain *types* of tests may remain positive long after other tests have become negative, even though they may be of the same relative range of sensitivity.

Treatment Schedule.—The amount of therapy and the length of time required to administer that amount of treatment may also affect the length of time to attain sero-negativity. As a rule, the higher the total dosage of penicillin and the longer the period of time during which the treatment is administered, the shorter the time to attain sero-negativity.

It must be pointed out, however, that there are many variations to the above factors, and no set rules can be made to determine or anticipate the length of time required to attain sero-negativity. Thomas[39] believes that patients who continue to have persistant strongly positive serologic reactions nine months after rapid therapy, should be re-treated as a precautionary measure. He emphasized the fact that one should not expect rapid reductions in serologic titers in such patients after re-treatment.

Serologic Differentiation Between Relapse and Re-infection

With the introduction of various forms of rapid treatment for early syphilis, many more patients are attaining serologic and clinical cures earlier than heretofore. Such patients are candidates for re-infections, and it is not an infrequent occurrence to find patients re-infected with their own spirochetes. This type of re-infection is very aptly called "ping-pong" syphilis. The individual acquires syphilis extramaritally and, after the development of the primary lesion, infects his marital partner. He receives adequate penicillin therapy and may attain a clinical and serologic cure within several weeks. During this time his wife has been incubating the spirochetes and re-infects him with his own spirochetes on subsequent sexual exposure.

The criteria for re-infection are quite rigid and, unfortunately, the patients are not observed at sufficiently frequent intervals to satisfy all of these requirements. It is, therefore, often quite difficult to determine whether such patients have developed a new infection or if there has been a relapse of the old infection.

At the Army Medical School we have had considerable experience with the serologic follow-up of patients with penicillin-treated early syphilis. A battery of serologic tests were performed with serums of such patients at weekly and monthly intervals. From our observtations we feel it is possible to distinguish between relapse and re-infection by carefully conducted serologic studies at frequent intervals. Following penicillin therapy in patients with early syphilis, there is usually a progressive reduction in serologic titer. In re-infection the patient usually attained and maintained complete sero-negativity followed by the development of a dark field positive, sero-negative

lesion at a new site. Shortly afterwards such patients developed sero-positive reactions with rapidly increasing titers. In treatment failures or relapse there was noted a sudden increase in serologic titer followed in about one month by clinical evidence of a muco-cutaneous relapse. If penicillin-treated patients would be subjected to serologic examinations at weekly or monthly intervals, it might be possible to predict a clinical relapse about one month before there is any clinical evidence, by a progressive increase in serologic titer on repeated examinations.

It is of utmost importance, therefore, to educate patients of the great need of reporting to physicians for serologic and clinical examinations at regular monthly intervals for at least one year following the completion of penicillin therapy.

Serologic Differentiation Between Prenatal Syphilis and Syphilotoxemia

Due to legislation passed by many states requiring routine prenatal blood testing, there has been an increased interest in the status of the offspring born of the syphilitic mother. These children may show no evidence of syphilis other than a positive serologic test. Many infants from adequately treated syphilitic mothers are subsequently proven to be nonsyphilitic even though positive serologic reactions are obtained with the cord or venous blood at birth. It is in this group that most errors in diagnosis have been made. Such infants do not have a true syphilitic infection, but the presence of reagin in the infants' blood is evidence of a transient syphilotoxemia. This type of reagin usually disappears within the first month of life, but may persist as long as three months.[5,15]

Serologic tests for syphilis in sero-positive infants should be performed at frequent intervals for a period of three months. If the tests become less positive or negative without specific treatment during that period, it is reasonable to consider that the infant is nonsyphilitic. If, however, the blood tests are positive at birth and remain positive, or if they are originally sero-negative and become positive by the end of the third month, it may be considered as indubitable evidence that the infant is syphilitic regardless of the serologic status of the mother. A comparison of the serologic titers of the mother and infant may be of great aid in determining the final status of the child. In the absence of any other evidence of prenatal syphilis (positive dark field examination of the umbilical cord, roentgenographic evidence of syphilitic bone involvement, or cutaneous manifestations of syphilis) antisyphilitic therapy should be withheld for at least three months.

It is unnecessary to collect the blood by venupuncture for each serologic examination, since sufficient blood can be obtained from a deep puncture wound of the infant's heel for the performance of a microflocculation test requiring only 0.05 ml. of serum.

Value of Routine Serologic Examinations

Most states now have laws requiring a serologic examination prior to marriage. These premarital laws have been quite worth while in detecting unsuspected cases of syphilis, but they have their limitations. For example, some states still forbid marriage of sero-positive individuals regardless of whether or not they are infectious. This is a serious mistake, since the majority of these individuals are in the latent and noncommunicable stage of the disease. The decision as to whether an indivual is in the infectious stage should rest with the physician, and he must decide if and when that individual may enter into marriage.

The importance of educating pregnant women to have a blood test as early as possible in their pregnancy cannot be overemphasized. The early detection of a syphilitic infection and the early and adequate administration of antisyphilitic therapy can and will prevent prenatal syphilis. Unfortunately, most laws do not require serologic examinations on newborn infants, and thus the advantage of the early detection and treatment of prenatal syphilis is lost.

There has been an increasing trend to routine serologic examinations of employes prior to employment and of applicants prior to the issuing of insurance policies. This is of value in detecting unsuspected cases and in directing them for treatment. It is important, however, to discourage the employer from refusing employment or for insurance companies from refusing to issue life insurance policies because the individual has a positive blood test.

Undoubtedly, serologic examination on induction into and separation from the armed forces uncovered a large number of persons with unsuspected syphilis. Adequate treatment will certainly prevent the occurrence of the serious late

sequelae of syphilis in the majority of these individuals.

Limitations of Serodiagnostic Procedures for Syphilis

While it is true that most positive serologic reactions obtained with our current nonspecific lipoid antigens are due to syphilis and perhaps represent some type of immunologic response, it is no less true that some positive results are unrelated to syphilis and represent a general biologic phenomenon. Such *false positive* or nonspecific reactions may be caused by a variety of infectious diseases, immunizations and metabolic disturbances. It has also been shown that similar nonspecific (nonsyphilitic) reactions may occur in individuals who show no evidence of any pathologic state. Since false positive reactions may occur in the absence of syphilis, unquestionably many persons have been stigmatized and have been given treatment solely on the basis of positive reactions disclosed by routine serologic examinations, in the course of, or immediately following, a nonsyphilitic disease. Compulsory preinduction, prenatal, premarital serologic examinations, and the increasing widespread use of routine blood testing in medical practice, industry, and on separation from the armed forces, have undoubtedly increased the number of individuals needlessly subjected to antisyphilitic treatment.

Since serodiagnostic tests are not truly specific for syphilis, the physician must be aware of which conditions, other than syphilis, may produce nonspecific (nonsyphilitic) reactions. Such reactions may be either technical or biologic. Technical false positives may occur in serums containing no antibodies and may be due to (1) technical errors in the collection and labeling of specimens, (2) the use of unsatisfactory blood specimens (contaminated or hemolyzed), (3) errors in the performance of the serologic tests, (4) the use of faulty materials and reagents in the test or (5) errors in recording or reporting the final results. With the improvement of serologic techniques and the use of improved materials, especially purified antigens of the cardiolipin type, there has been marked reduction in the incidence of technical false positives.

Biologic false positives are due to (1) the presence of antibody-like substances similar to the antibodies produced in syphilitic diseases, (2) an increase or alteration of the sero-globulin fraction or (3) an increase or alteration of some chemical substance or substances in the blood.

As a result of a series of studies at the Army Medical School, it was found that there are a number of factors involved in the incidence of false positive reactions for syphilis.[35] Time does not permit a discussion of all of these factors, but it was found that almost any condition may evoke a nonspecific reaction in a susceptible individual (serologic reactor). A number of procedures have been suggested to establish the existence of nonspecific reactions. Since the majority of these reactions are of the transient type and revert to sero-negativity within a short period of time, it is suggested that all individuals with positive serologic reactions for syphilis, unconfirmed by history or clinical evidence, should be followed serologically and without treatment for a period of three months, serologic tests being performed at two- to four-week intervals. At the end of that time the patient should be completely re-appraised to ascertain whether or not syphilis may be present. A continuing drop in serologic titer in a relatively short period of time, without the administration of antisyhilitic treatment, is strong evidence in favor of nonspecific serologic reactions. Irreparable harm has been done by an ill-considered or hasty diagnosis. If treatment is started prematurely, the evidence which could finally lead to an accurate diagnosis is often obscured. Serologic tests may become negative with a few injections, and one is at a loss to know whether the sero-negativity represents response to therapy or merely reflects the fact that the patient never had syphilis.

Another serious limitation of our serodiagnostic procedures is the occurrence of *false negative* reactions. When the serum of a patient with clinical syphilis gives a negative reaction, that patient is said to have sero-negative syphilis, and the reaction is considered as falsely negative. Actually the serum contains so little reagin that the particular test used is unable to detect its presence. Yet, if that same serum is re-checked by a more sensitive test, it would frequently yield a positive reaction. Such discrepancies are often observed in patients with primary syphilis. After the development of the primary lesion, the serum may give negative reactions with the insensitive tests for three weeks or longer, while with the more sensitive tests, a positive reaction may be obtained

within a few days after the appearance of the chancre. In an unpublished study[32] of experimental syphilis in rabbits, it was possible to detect the evidence of syphilis by means of a sensitive serologic test as much as five days before the clinical appearance of the chancre. This suggests, at least, that reagin begins to appear in the blood serum soon after inocculation with the treponema pallidum, but the routine tests are not sufficiently sensitive to detect their presence. Therefore, the incidence of sero-negative primary syphilis does not depend only on the time which has elapsed since inocculation, but more so on the sensitivity of the tests employed.

The same holds true in sero-negative late syphilis. It is not uncommon to find that patients with syphilis of the aorta may have negative blood tests. In the literature there are reports that the incidence of sero-negative cardiovascular syphilis and neurosyphilis is as high as 40 per cent. This high incidence is based on the fact that the tests used in these investigations were relatively insensitive. When the very sensitive tests are used, the incidence of negative reactions is markedly decreased. Therefore the number of cases of sero-negative late syphilis does not depend on the clinical manifestations of syphilis, but rather on the sensitivity of the particular tests. Yet even with the most sensitive tests available today, one occasionally obtains a negative reaction in a patient with clinical syphilis. The clinician, therefore, must be careful in the interpretation of serologic reports because syphilitic patients may give negative reactions.

Sero-negative syphilis may be due to a number of factors, as (1) the amount of antibody is minimal and cannot be detected by tests with ordinary sensitivity, (2) the presence of too much antibody so that false negative zone reactions occur, (3) the use of serologic tests with low levels of sensitivity, (4) the use of fresh serum containing considerable amounts of thermolabile-inhibiting substances, and (5) the presence of a thermastabile-inhibiting substance in the albumin fraction of the serum.

Verification Tests in the Serodiagnosis of Syphilis

The difficulties of basing a diagnosis of syphilis on current serodiagnostic tests alone have been pointed out by Moore, Eagle, and Mohr.[23] They have suggested some sixteen procedures of value in differentiating true from false positive reactions. Many of these procedures require special clinical and laboratory techniques, and often necessitate weeks or months of observation and expert syphilologic advice. In view of these conditions there is need for a method which will differentiate the false from the true reactions. Several "verification" or "confirmation" procedures have been proposed for this purpose.[10-12,16,17,40,41,43] Investigators[4,6,24,31] have reported that antigens for complement-fixation tests made from cultured spirochetes are far more specific than tissue extract antigens. Other investigators[13,14,20] have found the spirochetal test to be no more specific than the routine tests. In the Washington Serology Conference[30] both Richter and Eagle participated with spirochetal antigen complement-fixation tests as well as with the standard procedures employing lipoid antigens. More false positive serologic reactions were obtained in some nonsyphilitic diseases with the spirochetal antigens than with the lipoid antigens; however, in the leprosy group the incidence of false positive reactions was considerably lower with the spirochetal antigens than with the lipoid antigens. The increased specificity of spirochetal antigens has not been definitely established, and the occurrence of positive reactions with these antigens cannot be accepted as indicative of a syphilitic infection. Rein and Pillemer[37] found that fresh unheated serum inhibits or retards the aggregation of lipiodal antigens by the serums of syphilitics. Of greater interest was the finding that fresh serum had little or no effect on the aggregation of lipiodal antigens by the positive serums of horses and cows or the positive serums from nonsyphilitic individuals. Based on these findings, an "inhibition procedure" was devised with the belief that it might differentiate between true and false positive serological reactions for syphilis. Several thousand serums have been subjected to this experimental inhibition procedure. At first the results were exceptionally good and most encouraging. Before long, however, it was found that this method had definite limitations. The other verification, confirmation, and spirochetal complement-fixation tests also had limitations which rendered them unsatisfactory for practical use.

Neurath and his associates have made extensive studies[25] relating to the problem of biologic false positive reactions in serologic tests for syphilis and have developed a globulin-inhibition method for differentiating true from false positive reac-

tions. In a large series of carefully selected blood specimens, their method has been successful in distinguishing between these two types of reactions in about 95 per cent of the cases. This method is now under investigation in laboratories other than the originator, and it is hoped that it will give equally as good results.

Several methods have been developed for the differentiation of the true (syphilitic) serologic reactions from the false positive (nonsyphilitic) serologic reactions. None of these methods (except possibly for the globulin-inhibition method of Neurath) has been able to distinguish consistently between the true and false positive serologic reactions. There is need for such a procedure which is reliable, and investigation along these lines should be subjected to critical evaluation by independent workers before it is adopted as a routine procedure.

Conclusions

1. Modern serodiagnostic tests for syphilis, employing purified antigens, are extremely valuable to the physician in establishing or excluding a syphilitic infection.

2. With improvement in techniques and materials employed, the specificity and sensitivity of the serodiagnostic procedure has been appreciably increased.

3. There are certain limitations (false negative and false positive reactions) inherent in the currently employed tests. The physician must be aware of these limitations, for otherwise serious errors of omission and commission will be made.

4. There is a great need for the development of a procedure which would consistantly differentiate between true and false positive reactions.

References

1. Brown, R.: Cardiolipin in macro- and micro-precipitation tests for syphilis. J. Bact., 49:199, 1945.
2. Brown, R.: Cardiolipin, lecithin and cholesterol in the antigen in the precipitation test for syphilis. J. Bact., 47:581, 1944.
3. Bukantz, S. C.; Rein, C. R., and Kent, J. F.: Studies in complement fixation: II. Preservation of sheep's blood in citrate dextrose mixtures (modified Alsever's solution) for use in the complement-fixation reaction. J. Lab. & Clin. Med., 31:394, 1946.
4. Capelli, E.: La "Pallidareazione" di Gaehtgens sui sieri lebbrosi. Gior. di battenol. e immunol., 22:425-436, 1939.
5. Cregor, F. W., and Dalton, J. E.: Arch. Dermat. & Syph., 35:380, 1937.
6. Eagle, H.: Hogan, R. B.; Mohr, C. F., and Black, S. H.: On the reactivity of the serum and spinal fluid of leprous patients with spirochetal suspensions. Am. J. Syph., 25:397-405, (July) 1941.
7. Fromer, S.; Cutler, J. C., and Levitan, S.: Masking of early syphilis by penicillin therapy in gonorrhea. Ven. Dis., Inform., 27:174, 1946.
8. Harris, A., and Portnoy, J.: Cardiolipin antigens in the Kolmer complement-fixation test for syphilis. Ven. Dis. Inform., 23:353, 1944.
9. Harris, A.; Rosenberg, A. A., and Riedel, L. M.: A microflocculation test for syphilis using cardiolipin antigen, preliminary report. Ven. Dis. Inform., 27:169, 1946.
10. Hecht, H.: Eine neue Flockungsreaktion bei Syphilis. Deutsche med. Wchnschr., 47:1487-1488, (Dec. 8) 1921.
11. Hecht, H.: Personal communication, 1940.
12. Hecht, H.: Zum Wesen der Wassermannschen Reaktion. Prager med. Wchnschr., 39:316-317, (June 18) 1914.
13. Heinemann, H.: Uber die Praktische Brauchbarkeit der Pallidareaktion im Arbeitkreis des Tropenarsts. Arch. f. Schiffs-u. Trophen-Hyg., 36:9-19, 1932.
14. Heinemann, H.: Untersuchungen mit der Pallidareaktion, Dermat. Wschnschr. 94:680-689, (May 14) 1932.
15. Ingraham, N. R., Jr.; Shaffer, B.; Spence, B. E., and Gordon, J. H.: Arch. Dermat. & Syph., 43:323, 1941.
16. Kahn, R. L.: A serologic verification test in the diagnosis of latent syphilis. Arch. Dermat. & Syph., 41:817-830, (May) 1940.
17. Kahn. R. L.: The verification test in the serology of syphilis. J. Lab. Clin. Med., 28:1175-1186, (July) 1943.
18. Kent, J. F.; Bukantz, S. C., and Rein, C. R.: Studies in complement fixation: I. Spectrophotometric titration of complement; construction of graphs for direct determination of the 50 per cent hemolytic unit. J. Immunol., 53:37, 1946.
19. Kline, B. S.: Cardiolipin antigen in the serodiagnosis of syphilis. A microflocculation slide test. Am. J. Clin. Path., 10:68, 1946.
20. Kolmer, J. A.; Kast, C. C., and Lynch, E. R.: Studies on the role of Spirochaeta pallida in the Wassermann reaction; complement fixation in syphilis, leprosy, and malaria with spirochetal antigens. Am. J. Syph., 25:300-318, (May) 1941.
21. Leifer, W., and Martin, S. P.: Effects of penicillin on course of early syphilis. J.A.M.A., 130:202, 1946.
22. Maltaner, E., and Maltaner, F.: The standardization of the cardiolipin—lecithin—cholesterol antigen for the complement-fixation test for syphilis. J. Immunol., 51:195, 1945.
23. Moore, J. E.; Eagle, H., and Mohr, C. F.: Biologic false positive serologic reactions for syphilis: suggested method of approach to their clinical study. J.A.M.A., 115:1602, 1940.
24. Nagell, H.: Ueber das Vorkommen unspezifischer Remmungen bei der Wassermannschen Reaktion. Dermat. Wchnschr., 90: 795-802, (June 14), and 90:823-836, (June 21) 1930.
25. Neurath, H.; Vollcin, E.; Craig, H. W., and Erickson, J. O.: Personal communications.
26. Pangborn, M. C.: Acid cardiolipin and an improved method for the preparation of cardiolipin from beef heart. J. Biol. Chem., 153:343, 1944.
27. Pangborn, M. C.: A new serologically active phospholipid from beef heart. Proc. Soc. Exper, Biol. & Med., 48:484, 1941.
28. Pangborn, M. C.: A note on the purification of lecithin. J. Biol. Chem., 137:545, 1941.
29. Pangborn, M. C.: Isolation and purification of a serologically active phospholipid from beef heart. J. Biol. Chem., 143:247, 1941.
30. Parran, T., et al.: Preliminary report on the Washington Serology Conference. Ven. Dis. Inform., 23:161, (May) 1942.
31. Patrick, D. W., and Wolfe, D. M.: Leprosy: complement fixation with Gaehtgens' spirochete antigen compared with standard Wassermann and Kahn tests. Pub. Health Rep., 56: 1757-1759, (Aug. 29) 1941.
32. Rein, C. R.: Seronegative syphilis. (Unpublished)
33. Rein, C. R., and Bossak, H. N.: Cardiolipin antigens in the serodiagnosis of syphilis. A microflocculation slide test. Am. J. Syph., Gonor. & Ven. Dis., 30:40, 1946.
34. Rein, C. R., and Bossak, H. N.: Merthiolate (sodium ethyl mercuri thiosalicylate) as a preservative in sera for the serodiagnosis of syphilis. Am. J. Syph., Gonor. & Ven. Dis., 30: 342, 1946.
35. Rein, C. R., and Elsberg, E. S.: Studies on the incidence and nature of false positive serologic reactions for syphilis. Am. J. Clin. Path., 14:461, 1944.
36. Rein, C. R., and Hazay, C. E.: Rapid heating of serums for the Kline tests for syphilis. Am. J. Clin. Path., 10:228, 1940.
37. Rein, C. R., and Pillimer, L.: A new inhibition procedure to differentiate the syphilitic from the nonsyphilitic serologic reaction. (Unpublished)
38. Sawyer, H. P., and Bourke, A. R.: Antisheep amboceptor production with elimination of rabbit shock. J. Lab. & Clin. Med., 31:714, 1946.
39. Thomas, E. W.: The clinical significance of quantitative serologic tests for syphilis. Am. J. Syph., Gonor. & Ven. Dis., 30:317, 1946.
40. Wassermann, A.: Neue experimentelle Forschungen uber Syphilis. Berlin klin, Wchnschr., 58:193-197, (Feb. 28) 1921.
41. Wassermann, A.: Weitere Mitteilungen uber die Zerlegung des Wassermannaggregates und ihre Anwendungsfahigkeit zur Bestatigung der positiven Wassermannschen Reaktion. Klin. Wchnschr., 1:1101-1102, (May 27) 1922.
42. Wassermann, A.; Neisser, A., and Bruck, C.: Eine Serodiagnostische Reaktione bei Syphilis. Deutsche med. Wchnschr., 32:745, 1906.
43. Witebsky, E.: Eine bestatigungesreaktion zur Serodiagnostik der Syphilis. Zschr. f. Immuniforsch. u. exper. Therap., 80:323-335, (Oct. 5) 1933.

Concept of Arterial Hypertension

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In 1932, GOLDBLATT[13] and his collaborators reported the first of a series of experiments showing that partial constriction of the renal arteries of animals was followed by arterial hypertension. By means of a special clamp applied to the main renal arteries of dogs, monkeys, and rats, it was shown that by varying the degree of narrowing of the arterial lumen, thereby producing various degrees of renal ischemia, an arterial hypertension of the benign type with little or no renal functional disturbance, or of the malignant type with definite kidney damage, could be produced at will. These observations were shortly confirmed by numerous other investigators,[11] including Page,[22] who has done further extensive experimentation, including the observation that a definite hypertension is also produced when the kidney is surrounded by cellophane or silk, producing a perinephritis with a fibrous capsule, the removal of which relieves the hypertension.

The importance of these experimental findings as a step forward in our understanding of arterial hypertension was immediately recognized. They created a renewed widespread medical interest in a condition of previous obscure etiology, and stimulated a great increase of experimental and clinical observation. Earlier observers had shown that there was a relationship between kidney disease and vascular hypertension, but none had shown it so graphically. Richard Bright suspected such a relationship a century ago by observing that an enlarged heart was usually found with kidney disease. Other investigators in more recent years have also insisted on such a relationship.[8] A pressor substance extracted from the kidney many years previously escaped the attention which it deserved because a definite chemical amine could not be detected.[20]

From the Department of Internal Medicine, Harper Hospital, Detroit, Michigan. Read at a meeting of the Detroit Academy of Medicine, March, 1945.

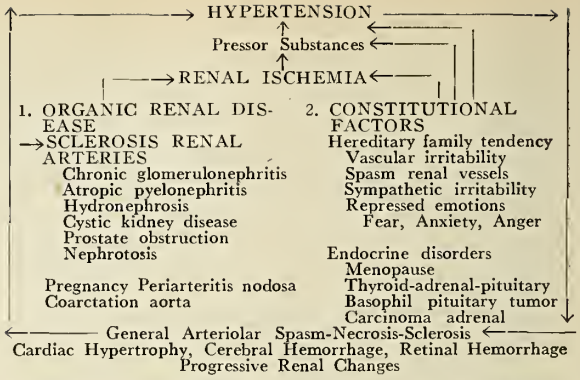

Diagram 1. The etiology of arterial hypertension as diagrammed above presupposes the existence originally of at least two factors, one constitutional, the other renal (pressor substances), which combine to produce a third factor, arteriolar sclerosis and narrowing, which in turn causes more hypertension and also more renal ischemia. A vicious circle is produced.

Not long after the experimental demonstration that renal ischemia produced hypertension, there began to appear clinical reports showing that at times, the surgical removal of a diseased kidney for a hypertensive patient led to a return to normal of the blood pressure. These reports seemed to prove that a unilateral diseased kidney may at times cause a definite arterial hypertension.

This discussion aims to present briefly the observations and viewpoints from the fields of experimental investigation, internal medicine and surgery and to present a concept of the mechanism of arterial hypertension. The opinions of Schroeder[25] regarding such a mechanism seem to conform best with demonstrated observations. It is probable that hypertension is rarely the result of a single factor, but is the result of two factors which cause a third similar factor to come into being. The relative severity of these different factors determine the progress and the severity of the disease.

Mechanism of Arterial Hypertension

In Diagram 1, I have attempted to portray the concept of hypertension herein discussed. It shows that the following factors are at work in most cases of hypertension: (1) renal ischemia, (2) the production of pressor substances, (3) a constitutional nervous factor, and (4) the damaging effect of continued hypertension on the arterioles. A vicious circle is in effect.

1. *Renal ischemia* means a decreased flow of arterial blood through the kidneys. This may be due to a narrowing of the afferent arteries or arterioles by sclerotic changes or spasm. Arterioscle-

rotic changes in the renal vessels are thought to be the most common initiating factor, as seen in clinical arterial hypertension. Narrowing of the efferent arterioles may also cause a decreased total blood flow. Both of these conditions may be caused by numerous types of renal pathology.

Glomerulonephritis, both acute and chronic, has long been known to be frequently associated with hypertension, and the pathologic lesions found at post mortem suggest that renal ischemia may have been present. Chronic pyelonephritis, hydronephrosis, nephroptosis, polycystic kidney disease and urinary obstruction have been reported as causes of renal ischemia and hypertension. Cases of these conditions have been reported in which the surgical removal of such a unilateral diseased kidney was followed by a return of the blood pressure to normal.

Such surgical kidney disease is, however, but rarely a cause of arterial hypertension, as evidenced by the reports of Braasch, Walters and Hammer,[4] of Crabtree and Chaset,[7] of Schroeder and Fish,[26] and of Mulholland.[19] Of a large number of patients with surgical kidney disease, about the same percentage (20 per cent) had hypertension as is observed in any average group of adult patients. However, in the case of severe atropic pyelonephritis, about 45 per cent showed hypertension, and removal of the infected kidney caused the blood pressure to return to normal in 70 per cent of those having hypertension before operation. Extensive renal and vascular sclerosis was present in all of the surgically removed atropic pyelonephritis cases and yet only 40 per cent showed hypertension. It has been remarked, "It would seem that certain systemic factors exist in one individual which cause hypertension in the presence of a renal lesion, but that existence of the same renal factors does not affect the blood pressure in another individual."[4]

Hypertension occurs in approximately 15 per cent of all persons and in about 33 per cent of persons more than fifty years of age.[16] Therefore, the incidence of high blood pressure would be high in any group of persons suffering from renal or any other disease.

Arteriosclerotic plaques were found causing a reduction in the lumen of the main renal arteries in 86 per cent of fifty cases of essential hypertension, while control cases showed only 10 per cent with comparable lesions.[3]

An interesting explanation of the hypertension of pregnancy is given by Gabriele.[10] It is contended that the kidney is raised, especially late in pregnancy, thereby changing the piezometric angle of the renal arteries and causing a renal ischemia with the subsequent liberation of pressor substances.

Hypertension has been reported in cases of periarteritis nodosa in which the renal arteries were involved and ischemia resulted. Also in coarctation of the aorta, hypertension has been noted as a result of decreased renal blood flow.

2. *The Production of Pressor Substances.*—When the renal blood vessels are diminished in caliber, there is produced more of a slow, steady flow of blood rather than a pulsating one. The pulse pressure is lowered, the blood flow slows and there is a relative anoxia. Under these conditions of ischemia, renin, a protein present in the cortex of normal kidneys, is liberated into the general circulation. Renin itself is not a vasoconstrictor, but in the blood stream, it unites with a pseudoglobulin, forming a substance called angiotonin, which is a highly active vasoconstrictor of a special sort. Angiotonin causes a constriction of small arteries and arterioles and an augmented heart beat, thereby raising the blood pressure. It does not cause a closure of the capillaries with a decreased peripheral blood flow and paleness, as is the action of adrenalin and posterior pituitary extract. This is the explanation of Page.[20] Another explanation is that the kidneys contain an enzyme which oxidizes certain amines only in the presence of abundant oxygen, but when there is an ischemia and anoxia, many amines are formed and liberated which are marked pressor substances.

3. *The Constitutional Factors.*—There is a marked hereditary tendency towards hypertension in many families. About 80 per cent of hypertension cases show a family history of hypertension. Investigation has shown that children in these hypertension families often react excessively to tests of vascular irritability, and those that do have this vascular irritability are more apt to later develop high blood pressure.[2] By means of the Cold-Pressor Test,[17] abnormal vasolability can be detected before the appearance of high blood pressure. There has been found some practical prophylactic value in the early detection of such cases.[30]

It has previously been mentioned that among people having the same degree of pyelonephritis and renal sclerosis in their surgically removed kid-

ney, studied pathologically, some develop hypertension while others don't.

Individuals who have hypertension are apt to have a high-strung, excitable emotional disposition and a build of the sthenic, stocky, short-necked type.

From an experimental standpoint, it has been found that constriction of the blood flow of one kidney in rats usually causes hypertension and often renal arteriolar necrosis, while in dogs it is usually necessary to produce ischemia in both kidneys in order to produce these changes. Only the excitable, nervous dog will respond to a lesion of one kidney alone.

Physicians are familiar with the marked, though transient, effect of the emotions of anxiety and anger on the blood pressure of many patients. The blood pressure is often high when taken by a new doctor in a strange office. I have seen it very high in patients who were worried because a doctor had recently found a high blood pressure and had left them with the impression that there was little or no treatment for the condition. The pressure may fall and the patients show much subjective improvement when they feel that their condition is understood and is being correctly treated by a new doctor.

The statement that "every psychic tendency seeks adequate bodily expression"[1] should be kept in mind in considering a hypertension patient. Inner tension, fear, or anger, which cannot be released through ordinary channels (action or words) may manifest itself in the vascular system.

The splanchnic sympathetic nerves are important in maintaining a normal or elevated blood pressure. When all of them are cut preganglionically, an elevated blood pressure is often reduced. Sympathectomy does not, however, according to experiments, cause an increased renal blood flow. Page[21] states that "A better explanation appears to be that the decrease of arterial pressure which follows sympathectomy in man is an expression of denervation of the reactive visceral splanchnic innervation with resultant partial failure of venous return most evident in the erect posture. The decrease of venous return limits cardiac output and thus tends to decrease arterial pressure."

Vasoconstriction of the renal vessels and ischemia can be produced by anxiety[28] as well as by direct stimulation of the sympathetics[5] and also by injections of adrenalin.[24] Prolonged arterial hypertension has not been produced by any of these methods,[9] yet it is possible that repeated psychic trauma, or prolonged repressed anxiety or anger in people predisposed by heredity, might produce enough renal vascular spasm and ischemia to become a permanent change.

Experimentally, injection of kaolin into the cisterna magna and also section of the inhibitory sinoaortic nerves produces a lasting hypertension, which is relieved by complete sympathectomy.[6]

Basophile tumors of the pituitary gland and some carcinomata of the adrenal produce a lasting arterial hypertension, which if prolonged, may show the resultant renal arteriosclerosis.

In experimental hypertensive animals, removal of the pituitary lowers the blood pressure. The same is true if both adrenals are removed when adequate doses of sodium chloride and adrenal cortex extract are given. Removal of one adrenal and only the medula of the other does not alter the blood pressure. Thyroidectomy and gonadectomy are without effect on hypertension in humans.

The conclusion seems to be that the adrenal cortex maintains the vascular tree in a state receptive to vasoconstrictor substances, such an angiotonin, but does not participate in the mechanism itself. The same applies to the role played by the nervous system.

4. *The Damaging Effect of Hypertension on the Vascular System.*—Elevation of the arterial tension is the result of a stimulus which causes constriction of the small arteries and arterioles and simultaneously, an augmentation of the heart beat, Angiotonin has these same pharmacologic effects. As the hypertensive process continues, the arteriolar spasm leads to a arteriolar muscle hypertrophy. The cells increase in size until they exceed the limits of efficient diffusion of nutriment into them and there ensues a necrotizing arteriolitis with fibrosis and sclerosis and a permanent narrowing of the arteriolar bed. The augmentation of the heart beat leads to cardiac hypertrophy and sclerosis.

General arteriosclerosis of the larger arteries is an entirely different entity with a different pathological and clinical picture. The sclerosis is in the intima of the larger arteries and not media of the arterioles.

As hypertensive arterial disease progresses, it becomes more and more manifested by cardiac hypertrophy and sclerosis, with clinical, x-ray, and electrocardiographic changes; by retinal hemorrhages and papilledemia; by progressive renal

changes, with urinary blood cells, casts and albumin; and by sclerosis in the cerebrum and other vital organs.

A situation is found in the kidneys which may not only be the effect of hypertension but may also cause hypertension—a vicious circle.

Experimental evidence supports this relation. Dogs, when subjected to bilateral renal ischemia and the resulting hypertension, develop arteriolar necrosis and sclerosis in other organs.[12] Rats rendered hypertensive by ischemia in one kidney develop the same lesions in the other kidney and other organs.[27]

Pathological examination has shown sclerosis of the afferent kidney vessels in all cases[18], and of the efferent kidney vessels in most cases[14], of arterial hypertension cases at autopsy.

Résumé of Arterial Hypertension Mechanism.—Two factors are necessary in the production of a persistent high blood pressure: (1) a constitutional vascular irritability or spasm tendency, and (2) renal ischemia. Each may cause the other, producing a vicious circle. Briefly stated, in individuals predisposed by constitutional nervous or endocrine vasospasm tendencies, the development of renal vessel sclerosis and renal ischemia, with the liberation of pressor substances, produces an accentuation of the vascular spasm and a continuous arterial hypertension. This hypertension by itself causes spasm, hypertrophy, narrowing and sclerosis of the terminal arterioles, including those of the kidney, and an irreversable vicious circle is produced. In the great majority of patients the vascular spasm factor initiates the disorder, but, occasionally the renal lesion is primary.

Management of Hypertension

Arterial hypertension can be controlled and its progress retarded in the great majority of patients, thereby giving such people many years of useful life.

A. Investigate carefully the possibility of the patient having a unilateral surgical kidney. This condition is rare as a cause of hypertension but it does exist occasionally.

B. Utilize all therapeutic measures which promote vascular relaxation, including rest, physical therapy, diet, medicines, psychotherapy and surgery.

1. Rest.—Most patients with hypertension are ambitious, responsible, forceful and high strung. They do not enjoy rest and relaxation. It is therefore often very difficult to impress upon the patient the necessity of such a method of living. They should be instructed to get ten hours in bed every night and one or two hours after the noon meal if possible. They should take vacations several times per year, and avoid fatigue especially.

2. Physical therapy.—A warm salt bath at bedtime generally is relaxing. Sweat baths and massage are good for the obese. Moderate exercise, such as golf and walking, is indicated if there is no cardiac failure.

3. The diet should be balanced in carbohydrate, protein, fat, minerals, and vitamins, with calories sufficient to reach or maintain the ideal weight for the patient. Reduction of the weight is advisible for those overweight. A very low protein diet for one or two months often helps in reduction of blood pressure, especially if the patient has previously been on too great a protein intake. Tobacco should be eliminated entirely. Alcohol in moderate doses is advisable for its relaxing effect. Coffee and tea should be limited to one or two cups per day. Water intake should be two to three quarts daily.

4. Medicines.—No one drug has been found to be the best in the control of hypertension. Several drugs and combination of drugs have been found to be of value when given careful control and observation.

(a) Sedatives may be given in adequate dosage for relaxation but not to interfere with cerebral activities. Any of the barbiturates may be used but the type of sedatives should be changed every month or so in order to avoid toxic action. Bromides are of value for periods of one or two weeks every one or two months. Whisky, one or two ounces after noon and night meals, is useful. Aspirin with codein is very relaxing during nervous or headache spells.

(b) Vasodilators: Manitol-hexanitrate after meals and at bedtime, especially in combination with a small amount of phenobarbital, will usually keep a blood pressure down within safe limits. Sulfocyanates in proper dosage will control blood pressure in about 50 per cent of cases. The blood cyanate level should be checked every few weeks.

When this precaution has been taken I have never seen any bad effect from the drug. Xanthine derivatives act chiefly on the coronary and kidney blood flow. Aminophylin, theobromin, and theocalcin are the drugs most used.

(c) Iodides are of little direct value except in the cases of mild hyperthyroidism.

(d) Estrone is of value if the menopause is a factor in pathogenesis, and testosterone may be of aid for the male.

5. *Psychotherapy.*—Liberal doses of optimism and encouragement should be given. The patient should be instructed and made to avoid all unnecessary strains, stresses and worries of life. This is now called by the psychiatrist "preventive psychiatry." The patient should develop a philosophy of life which "lets the other fellow worry," or "it will not matter much 100 years from now."

6. *Sympathectomy.*—This procedure, while a formidable operation, will often prolong a patient's life in comfort for many years. It is especially indicated in those cases of malignant hypertension which do not respond to the medical measures previously outlined. The operation should be done before too much damage has been done to the arterioles by the hypertension. Peet[23], Southwich[29], and Grimson[15] have been the greatest exponents of this form of treatment.

Summary

A concept of arterial hypertension is presented which presupposes a constitutional, probably hereditary, vascular sympathetic nervous irritability, which causes, or on which is superimposed, a renal ischemia. The combination of the two produces the vicious circle of arterial hypertension. Essential hypertension is a name given to an early stage of this condition before the renal ischemia has become very manifest by clinical tests. Malignant hypertension is a rapidly developing uncontrollable case. Treatment seldom cures, but generally it is able to control the progress of the disorder and prolong life in comparative comfort. The management of hypertension is outlined. Its value might be compared to the use of liver extract in primary anemia, or glasses in vision trouble.

References

1. Alexander, Franz: Psychotherapy. New York; W. W. Norton Co. Inc., 1937.
2. Ayman, E.: Arterial hypertension. Arch. Int. Med., 53:792, (May) 1934.
3. Blackman, S. S.: Arteriosclerosis and hypertension. Bull. Johns Hopkins Hosp., 65:353, 1939.
4. Braasch, W. F.; Walters, W., and Hammer, H. J.: Hypertension and the surgical kidney. J.A.M.A., 115:1837, (Nov. 30) 1940.
5. Burton-Apitz, R.: Physiology of hypertension. Am. J. Physiol., 40:437, 1916.
6. Corcoran, A. C., and Page, I. H.: High blood pressure. J.A.M.A., 116:690, (Feb.) 1941.
7. Crabtree, E. G., and Chaset, N.: Surgical kidney and hypertension. J.A.M.A., 115:1842, (Nov. 30) 1940.
8. Editorial: J.A.M.A., 110:49, (Jan. 1) 1938.
9. Freeman, N. E., and Page, I. H.: Arterial hypertension. Am. Heart J., 14:405, 1937.
10. Gabriele, W. J.: Effect of renal position on renal blood flow and function. Am. J. M. Sc., 204:227, 1942.
11. Goldblatt, H.: Arterial hypertension. Ann. Int. Med., 11:69, (July) 1937.
12. Goldblatt, H.: Harvey Lectures, 33:237, 1938.
13. Goldblatt, H.; Lynch, J.; Hanzal, R. F., and Summerville, W. W.: Studies on experimental hypertension. Bull. Acad. Med., Cleveland, 16:6, 1932; J. Exper. Med., 59:347, 1934.
14. Goldring, W.; Chasis, H.; Ranges, H. A., and Smith, H. W.: Arteriosclerosis. J. Clin. Investigation, 17:505, 1938.
15. Grimson, K. S.: The surgical treatment of hypertension. Internat. Abstr. Surg., 75:421, 1942.
16. Hines, E. A., and Lauder, H. H.: Incidence of hypertension. J.A.M.A., 116:1050, (Mar. 15) 1941.
17. Hines, E. A., Jr., and Brown, G. E.: Cold-pressor test. Ann. Int. Med., 7:209, (Aug.) 1933; Am. Heart J., 11:1, (Jan.) 1936.
18. Moritz, A. R., and Oldt, M. R.: Pathology of arterial hypertension. Am. J. Path., 13:679, 1937.
19. Mulholland, S. W.: Hypertension challenge to urology. J. Urol., 42:957, (Dec.) 1939.
20. Page, I. H.: Arterial hypertension. J.A.M.A., 120:757, (Nov. 7) 1942.
21. Page, I. H.: Arterial Hypertension. J. Urol., 46:807, (Nov.) 1941.
22. Page, I. H.: Production of persistent arterial hypertension by perinephritis. J.A.M.A., 113:2046, (Dec. 2) 1939.
23. Peet, M. M., and Isberg, E. M.: The surgical treatment of arterial hypertension. J.A.M.A., 130:467, (Feb. 23) 1946.
24. Richards, A. N. and Plant, O. H.: Hypertension. Am. J. Physiol., 59:191, 1922.
25. Schroeder, H. A.: Concept of arterial hypertension. Am. J. M. Sc., 204:734, 1942.
26. Schroeder, H. A., and Fish, G. W.: Arterial hypertension. Am. J. M. Sc., 199:601, (Mar.) 1940.
27. Schroeder, H. A., and Heuman, C. J.: Experimental arterial hypertension. J. Exper. Med., 75:527, 1942.
28. Smith, H. W.: Hypertension. Harvey Lectures, 35:166, 1940.
29. Smithwick, R. H.: Surgical treatment of hypertension. Arch. Surg., 49:180, 1944.
30. Stieglitz, E. J.: Arterial hypertension. J. Michigan M. Soc., 39:827, (Nov.) 1940.

MSMS

STOP—LOOK—LISTEN

STOP telling the patient there is nothing wrong with him but nerves—Don't say: Go home and forget it.
LOOK for the facts as the patient sees them.
LISTEN attentively to patient's story.

* * *

The patient who is always tired is more liable to be suffering from emotional fatigue than from anemia or avitaminosis.

* * *

The most valuable thing in the treatment of a nervous, emotionally disturbed patient is to have security—not to the point of too great dependency.

* * *

You can't treat the emotional problems in your own family.

* * *

Seventy-five per cent to 80 per cent of organic illnesses have unhealthy psychic components.

* * *

Psychosomatic symptoms arise from being unable to solve emotional conflicts arising from disturbing situations. These conflicts may be recent but in many cases are of remote origin.

MICHIGAN MENTAL HYGIENE COMMITTEE

Gynecological and Obstetrical Problems of the Industrial Physician

By Max R. Burnell, M.D., F.A.C.S.
Flint, Michigan

The present-day industrial physician is charged with the responsibility of inaugurating health maintenance programs which will aid in the reduction of lost time resulting from illness. That such programs should be the chief concern of those physicians specializing in this field of medicine is proven by the fact that the larger corporations who keep accurate records of sick absenteeism report that of every 100 days lost by the employe from illness or accident, only six of these days can be charged to an occupational cause; ninety-four of the 100 days lost are the result of *non-occupational* illness or accident.

Until recently, these health maintenance programs have been concerned mainly with such obviously disabling diseases as tuberculosis, syphilis, the common cold, digestive diseases, malnutrition, nervous and mental disorders, cardiovascular-renal disease, et cetera. With the enormous increase in the number of women employed during the war years, and at present with their largest peacetime employment, an added responsibility comes to the industrial physician—the establishment of a health maintenance program that will aid in the reduction of sick absenteeism resulting from illness peculiar to this group.

The problems that women bring to industry cannot be dismissed by stating that there are no widespread occupational diseases peculiar to women, nor that the high absenteeism rates of female employes are the result of their attempt at carrying on two jobs—the one in the factory, the other in maintaining the home.

In a recent study made by a large industry operating in thirty-six states, the disability rate for female employes was 292 per 1,000. These statistics covered illnesses lasting longer than one week. Gynecological disease, including acute appendicitis, accounted for 26 per cent of that total. During this same period, pregnancy was responsible for an absenteeism rate of forty-five per 1,000.

The industrial physician has found that the gynecological conditions most frequently brought to his attention and most commonly associated by the employe with her work are low back pain, dysmenorrhea, amenorrhea, excessive or intermenstrual bleeding, pelvic pain, the aggravation of symptoms of the menopause and pelvic relaxations (cystocele, rectocele and prolapse of the uterus).

What are his responsibilities in these cases, and what can he do in outlining a health maintenance program that will aid in their solution?

Pre-employment Gynecological Considerations

During the pre-employment physical examination, a knowledge of the previous health of the prospective employe is basic in evaluating the ability of that individual to do safely the job to which she has been assigned. It is of extreme importance to know whether there have been disabilities arising from dysmenorrhea, pelvic pain, repeated abortions, excessive menstrual flow or inter-menstrual bleeding, et cetera. It is just as basic that a pelvic examination should follow in the completion of such an evaluation.

X-ray of the chest, visual acuity tests, blood pressure readings, urine examinations and serological tests have become standard procedures in the pre-employment examination. Knowledge of any pathological state of the employe's pelvic organs is just as significant.

The importance of such knowledge becomes apparent when we study the trend of legislation relative to compensable occupational disease. Today, many of our state laws make little, if any, distinction between the liability of the employer in cases of disability arising directly out of employment, or such liability being the result of an aggravation of a pre-existing pathological state.

The prospective employe should be informed that the pre-employment examination is for the purpose of safe placement at work. It has been our experience that she readily accepts any examination that serves to protect her against disability or the aggravation of an already existing disease. Knowledge of past gynecological or obstetrical

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pathologic condition, along with pelvic examination, is a fundamental inclusion in adequate health maintenance programs for the industrially employed female worker.

Gynecological Problems of Established Employe

Definite gynecological disease arising solely from an occupational cause is rare. Aggravation of a previously existing condition is common, and gynecological symptoms that the employe attributes to her work are legion.

Dysmenorrhea—The problem of dysmenorrhea is one that has caused the industrial physician much concern—concern often to the point of exasperation. His experience differs radically from that of the gynecologist in the approach to a solution of this problem.

First, he finds an attitude of resignation to this periodic disability which is amazing—resignation to such a degree that it has rarely occurred to them to seek medical advice. In our series, less than 12 per cent of those absenting themselves from one to three days each month, had ever requested an examination by their family physician.

Secondly, the discomfort of menstruation has previously furnished a large percentage of young women with an excuse to stay home from school or the avoidance of any unpleasant tasks. This attitude is carried into their factory environment where, with the mere mention of abdominal cramps, they expect leave with no questions asked.

Lastly, "epidemic dysmenorrhea" may be unknown to the gynecologist, but it has frequently been observed by the industrial physician. The transfer of *one* young woman to a different type of employment, when it was thought that the work she was doing was aggravating her symptoms, may bring many requests from other employes who seek similar changes, claiming similar disability.

What must the industrial physician include in his program of health maintenance that will tend to lessen the lost time from this source?

Wards should be provided in the industrial hospital where immediate relief can be obtained. The employe should *not* be sent home. Rest, local heat and simple medication soon return most of them to their work. However, it is during the intermenstrual period that the most beneficial results can be obtained. A sincere attempt should be made to correct the mental attitude of the employe. Correction of improper posture at work, resulting in poor muscle tone, often necessitates change or rearrangement in her job. The importance of proper diet and the avoidance of constipation should be emphasized. Frequently, systematic exercises are outlined and outdoor activities encouraged.

By following such a program, one industrial institution employing over 9,000 women, reduced the lost time from dysmenorrhea approximately 75 per cent.

The industrial physician is responsible for the correction of conditions within the factory which cause abnormal changes in the congestive states of the menstrual cycle. It is not always the female employe who is on her feet all day, moving about before her machine, nor the one who is required to use her feet constantly in the operation of her job, who complains of dysmenorrhea. The women on the assembly lines, inspectors or clerks, who sit at tables or desks, find that these more sedentary occupations similarly cause alterations in their menstrual symptoms.

It is the industrial physician who must decide whether the employe should be relieved of strenuous tasks; advised to seek systematic exercise, or receive instruction in the physiology of menstruation that might result in a change in mental attitude towards this too often misunderstood normal function.

His must be a practical approach to this subject, for his ultimate goal is, after all, a type of health maintenance that reduces absenteeism and lessens disruption in production from this or any other periodic or repeated disability.

Finally, the industrial physician must always keep in mind that dysmenorrhea is but a symptom resulting from many conditions (pelvic inflammatory states, endometriosis, pelvic neoplasm, cervical stenosis, hormonal imbalance, et cetera) having nothing to do with employment. Such cases can best be treated by the employe's own personal physician.

Abnormal Menstrual Flow and Inter-menstrual Bleeding—The medical departments of our manufacturing institutions, functioning as "fact finding" agencies, have an unequalled opportunity for the recognition of early gynecological disease. Abnormal menstrual flow and inter-menstrual bleeding associated with ectopic pregnancy, threatened abortion, benign or malignant polyps, adenomyoma of the uterus, cervical cancer, et cetera, are fre-

quently first observed in those departments. When it is recognized that there is no occupational explanation for these symptoms, the insistence upon prompt medical attention has resulted not only in shortening the period of disability, but frequently has saved the life of the employe.

The diagnosis of early pulmonary tuberculosis in those industrially employed has been a recognized factor in the reduction of the death rate from that source. In the case of cervical cancer, especially, a similar service may be rendered by the industrial physician.

One cause of excessive menstruation or intermenstrual bleeding is of particular interest to the industrial physician. It has been noted that female employes working with certain chemicals, such as trichlorethylene, benzol, carbon disulfide, T.N.T. and lead, occasionally give symptoms of increased menstrual flow or "spotting" between their periods. The question immediately arises as to whether these chemicals have specific effects upon the female reproductive organs or whether their symptoms are merely manifestations of low grade toxic absorption resulting in hemorrhagic condition of the mucous membranes in *any* part of the body. In the case of lead, it is believed that there is a definite effect upon the reproductive function and the menstrual cycle.

The industrial physician's responsibility in this instance is to see that female employes are properly protected from such exposures.

Pelvic Pain and Low Backache—These symptoms have been grouped together, for they are commonly associated in the minds of the female industrial worker. The industrial physician again finds himself in an unenviable position, for, even when the employe knows that she has an existing pathologic condition, she only too frequently claims that her job is solely responsible for her symptoms.

A decision must be made at once. Is the basis for her complaint an inflammatory disease, cyst of the ovary, uterine fibroid, endometriosis, et cetera, or do these symptoms actually arise from lumbosacral strain, excessive fatigue, or bad posture at work? Pelvic examination is as essential, in these cases, as x-ray examination of the chest when pulmonary complications may be suspected.

When the industrial physician finds that a definite pelvic pathologic condition is present, it is his duty to see that these employes consult their family physician as to proper treatment.

Pelvic Relaxations—With the increased employment of older parous women in our industries, the problem of pelvic relaxations and their aggravation by certain types of work must be studied. Constant jarring, found in some riveting operations, heavy lifting, repeated uses of the feet in working certain power machines, or the requirement of standing long hours at a time, certainly aggravate the symptoms arising from cystocele, rectocele or a prolapsed uterus.

Actually these women should not be employed at this type of work. Transfer to lighter employment is one solution. When this is impossible, the industrial physician should see that these women be given sufficient rest periods to avoid excessive fatigue. Certainly it is his duty to examine the employe at frequent enough intervals to know whether her condition is becoming worse in spite of any change in occupation he may have insisted upon.

The male employe with hernia is given every attention. The problem of pelvic relaxation in the female must receive equal consideration.

Menopause—The menopause, with its associated nervous and vasomotor instability, increased excitability and susceptibility to fatigue, along with frequent attacks of vertigo, limits the type of work that these female employes should be allowed to do.

It is the responsibility of the industrial physician to recognize menopausal symptoms, see that proper medical care is instituted by the employe's own physician, and insist that she be placed at tasks requiring less nervous energy and concentration. Sympathetic understanding on the part of the industrial physician goes far in lessening lost time during this trying period.

Pregnancy—No phase of health maintenance for women in industry has received as much attention as that concerning pregnancy. The main problems involved are: should the employe continue at work once the diagnosis of pregnancy is established; under what circumstances should she be allowed to continue, and, if allowed to remain, what particular types of employment are safe, and what toxic exposures must be particularly guarded against.

State laws on this subject are few and inadequate. But four states (Massachusetts, Connecticut, Vermont and Missouri) legalize the length of

time the pregnant employe may remain at work, while only six (Washington, Connecticut, Massachusetts, New York, Vermont and Missouri) specifically state when she may be legally returned to work following the birth of her baby.

The industrial physician receives little guidance from this source. For example, a woman may, legally at least, be kept at work in Massachusetts or Vermont until two weeks before the estimated date of delivery, while in Connecticut, New York or Massachusetts she may be employed four weeks post partum, and in Missouri it is legal to place her at work in three weeks.

Fortunately, specific recommendations concerning pregnancy in the industrial female worker, have been prepared by the Children's Bureau, the Women's Bureau of the U. S. Department of Labor, and the Committee on Health of Women in Industry of the American Medical Association. These recommendations have been of great assistance to the industrial physician in formulating policies adaptable to the particular type of industry he serves.

A summary of these recommendations follows:

1. The labor situation in this country does not necessitate the recruitment or employment of pregnant women.

2. The employe, upon realizing that she is pregnant, should be urged to report her condition immediately to the industrial medical department, the Girls' Counselor, or to the superintendent of her department, so that transfer to lighter or less fatiguing work may result.

3. There should be no exposures to toxic substances considered to be extra hazardous during pregnancy, such as analine, benzol, toluol, carbon disulphide, carbon monoxide, chlorinated hydrocarbons, lead, mercury, nitrobenzol, phosphorus, radioactive substances or any other toxic substances that exert an injurious effect upon the blood-forming organs, the liver, or the kidneys.

4. Facilities for adequate pre-natal medical care should be readily available for all employed pregnant women; they should be instructed as to the importance of much care. Many industrial institutions require a note from the family physician stating that pre-natal care has been instituted before the employe is allowed to continue at work.

5. A minimum of six weeks' leave before delivery should be granted. (The word "minimum" should be emphasized, for in many occupations employment beyond the six-month period is extremely hazardous.) It might be added that, where there is a previous history of repeated abortions, severe toxemias, existent pyelitis, kidney or heart disease, serious varicosities or sacro-iliac difficulties, the employe should be placed on a medical leave of absence, and the industrial physician should furnish the obstetrician with any data he may have accumulated concerning this individual, such as reports of urine analyses, blood pressure readings, blood tests, x-ray findings, et cetera.

As the disability rates for premature termination of pregnancy are rising, closer co-operation between the industrial physician and the obstetrician is mandatory.

6. It is recommended that, in uncomplicated cases, a period of six weeks should follow delivery before the new mother should be returned to work. (Here again, that this is a "minimum" period should be given emphasis.)

This last recommendation is one which causes the industrial physician considerable apprehension. The Unemployment Compensation Commission Act complicates the decision he has to make.

At the time of the final postpartum examination, the employe requests a statement from her physician that she now is able to return to work. She then goes before the commission, using this note to establish that she "is able and available for her previous position." This being established with the commission, she is referred to her former employer.

At this point, the industrial physician is in difficulties. If he is hesitant about placing the employe at work, feeling that her job at the factory and her added responsibilities at home are more than she is physically capable of doing without damage to her health, she then is entitled to unemployment benefits. If he indiscriminately approves these new mothers for return to work, using the family physician's note as his authority, he is certainly not forwarding his health maintenance program.

This is but another instance where a better mutual understanding of the problems of the industrial physician and the family physician would benefit both and the employe as well.

Conclusion

The industrial physician's consideration of gynecological and obstetrical problems is but a part of

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Tumors of the Female Breast

A Diagnostic and Therapeutic Summary

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Undoubtedly, no discussion of a disease that claims, as breast cancer does, over 16,000 lives yearly,[30] can be considered untimely or trite. What makes it, however, even more proper to return again and again to a review of our knowledge of the new-growths of the breast is the circumstance that practically all this enormous loss of life is preventable. The opportunity is rare where one can uncover a neoplasm as early as in the breast, and it is precisely in early detection that our hope of a greater saving of lives rests. The rate of early diagnosis will increase proportionately as our patients learn to seek medical advice about any lump discovered in the breast and as we physicians, ourselves, learn to look upon any such lesion with the seriousness it rightfully demands. This is to say that we shall do our duty in full only if we regard the diagnosis of any swelling in the female breast as the differential diagnosis of breast cancer. Some of the cardinal points of this differential diagnosis form the theme of this brief discourse.

Methods of Examination

The minutiae of physical examination are too well known to be discussed here. One must stress, however, even at the risk of sounding elementary, the importance of thoroughness in the examination of the breasts of all the female patients who, for any reason, present themselves for general physical examination. The discovery of an early breast cancer during a routine physical examination is nothing short of an act of life saving; it is one of the gratifying rewards of our profession. Its oversight is a disaster we can hardly excuse. One may also mention that a too vigorous search of the axilla for lymphnode enlargement is not to be recommended in a case of suspected cancer. The margin of error is great[13] and the danger of traumatizing a cancer-bearing gland is real.

One may advantageously resort in the investigation of a breast tumor to transillumination in a darkroom. This method often yields information about the density and configuration of a tumor. Aspiration, likewise, is useful in determining the nature of a suspected cyst. Radiography after the injection of an opaque material—so-called galactography—has been advocated by some but this method has found little general acceptance.

General Principle of Procedure

As it has just been mentioned, our attitude in the presence of a tumor of the breast must be that of suspicion, that of suspecting carcinoma until convinced otherwise. There is only one dependable means of being convinced: the microscopic report of the pathologist. Thus, all tumors of the breast must be excised for biopsy. We have long followed the practice of doing these biopsies with the full preparation for a possible radical operation, the details of which will be outlined presently. We shall first review, however, very briefly the commonest lesions that call for biopsy, indicating at the same time their definitive treatment.

Inflammatory and Traumatic Swellings

Among the pyogenic infections of the breast, the diffuse phlegmonous type may at times raise the problem of differentiation from a rapidly growing and highly malignant carcinoma. Thick-walled chronic pyogenic abscesses may cause a similar difficulty. Both instances are rare and the biopsy will decide the diagnosis. A therapeutic test with penicillin may be helpful.

The circumscribed, nonsuppurative forms of specific granulomas, especially the proliferative type of tuberculosis, occasionally are impossible to distinguish from malignant neoplasm grossly. Biopsy is essential for the diagnosis. Generally a simple mastectomy is the treatment.

Trauma to the breast may lead to tumor formation by causing focal necrosis of the adipose tissue. The necrotized fat may liquefy and result in a pseudo-cyst, or it may become fibrotic and form a nodule whose fixed and hard character may easily remind one of cancer. These nodules and false cysts may best be removed, unless their origin is obvious. It may be added that, besides the ordinary hematoma, the traumatic cyst and

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nodule are the only breast lesions which can rightfully be attributed to the effect of injury, although many a patient with breast cancer is wont to trace her trouble to a blow or similar trauma.

Hormones and the Female Breast

In an evaluation of the next group of breast tumors, the true neoplasms, an understanding of the factors governing mammary development is helpful.[24]

As a physiological division of the female reproductive system, the breast is subject to the same hormonal stimuli as the other tissues serving the purposes of reproduction. The estrogens have a growth-promoting effect on the duct system and perhaps, also, on the periductile connective tissue. In combination with the estrogens, the secretion of the corpus luteum, progestin, stimulates alveolar and lobular development. In addition to the ovarian hormones, pituitary secretions have also been found necessary for the normal development of mammary tissue and for the secretion of milk (lactogenic hormone or prolactin).

Numerous experimental and clinical observations have been made that suggest that neoplasms of the breast have an etiologic relationship to the state of balance of the hormonal factors acting upon the functioning breast tissue. Some of these will be indicated presently. It should be stressed, however, that much of our concept of this hormonal mechanism is speculative.

Fibroadenoma

This discrete, usually single, freely movable and ovoid or spherical tumor is the commonest surgical lesion of the breast of the woman in the third and fourth decades of life. When cut grossly, its surface is grayish-white and somewhat rubbery, with darker and slightly raised foci scattered through it. The latter represent the glandular elements in the fibrous bulk of the tumor. A well-circumscribed capsule is present, and the tumor shells out easily at operation. Fibroadenomas probably represent a localized response to the normal hormonal stimulation to which the breast is subject. There seems to be a predisposition for sarcoma to develop in fibroadenomas, but it is questionable that carcinoma may arise from this neoplasm.[33] The treatment is local surgical excision.

Fibrocystic Disease (Chronic Cystic Mastitis)

This pathological complex comprises a varied group of neoplastic changes[3,5-7,17,27,32] and is the breast lesion most commonly seen in surgical clinics. It is likewise the lesion that poses the most trying questions of differential diagnosis and management.

It simplifies the understanding of this disease if one conceives of its various forms as quantitatively different combinations of certain qualitatively similar pathologic changes. These changes are essentially as follows: proliferation of the acinar epithelium, dilatation of the duct system with or without epithelial hyperplasia and with or without cyst formation, hyperplasia of the connective tissue elements, and focal lymphocytic infiltrations (the latter feature having given ground for the name of chronic mastitis, even though the disease is not an inflammatory one). These alterations occur in varying combinations and proportions, now the epithelial proliferation predominating, now the fibrosis being more pronounced, then again the cyst formation being the most marked. For practical considerations, the forms with epithelial hyperplasia are the most important ones since these may represent precancerous lesions. Unfortunately, clinicially the differentiation of one form from another is usually impossible. In general, they present a rather diffuse "lumpiness," the glandular substance of the breast being irregularly thickened and somewhat rubbery and worm-like; discrete condensations of tissue that may be cystic or firm (in the latter case very closely resembling cancer), and also frank cysts, are often palpable. It is the circumscribed nodule that, as a rule, brings the patient to the surgeon. The disease involves the entire mammary gland and is almost invariably bilateral, although there may be a marked difference in the degree of involvement between the two sides and in the various segments of the same breast.

The entities called *adenofibrosis, chronic mastitis* and *cyclic hyperplasia* may best be regarded as graded phases of the general picture of fibrocystic disease.

In the causation of all the forms of fibrocystic disease, a hormonal factor plays a definite role. In the fully developed form, one very likely deals with a prolonged estrogenic stimulation without the necessary counterbalance of the corpus luteum hormone. A striking clinical feature of the more advanced disease is its prevalence in nulliparous women and in the postmenopausal age group.

The great practical importance of chronic cystic mastitis lies in its relationship to the develop-

ment of carcinoma. The opinions are not yet unanimous, and the evidence is complex and somewhat confusing.[3,5-7,17,27,32] Some practical facts may, however, be profitably pointed out. There is no doubt, for instance, that a certain number of breasts with fibrocystic disease contain areas of epithelial hyperplasia that are actually or potentially precancerous. One even encounters foci of changes that are microscopically malignant. Moreover, clinically these breasts are usually indistinguishable from those that have no malignant potentialities. On the other hand, the proportion of breasts with fibrocystic disease that carry the danger of malignant change is not sufficiently great to warrant surgery of the more radical type (simple or radical mastectomy) as a routine treatment of the disease. With these considerations in mind, one is able to outline a method of management that will combine a justified conservatism with a cautious regard for the possible risks.

In all cases that show the characteristic diffuse changes without a localized mass or nodule, repeated observations at three- or six-month intervals are advised. When a palpable mass is found, its prompt removal for biopsy is urged. If the lesion on frozen section is reported benign, no further surgery is done. In case the microscopic picture discloses hyperplasia of precancerous potentiality, and particularly if this occurs in a woman over fifty, a simple mastectomy is performed. If a benign nodule recurs, usually simple mastectomy is advised. In the latter case, however, the patient's age and her attitude toward losing her breast are considerations that may influence one to prefer repeated excision to simple mastectomy. Unless there are definite local changes in the opposite breast, which are judged on their own merits, we do not perform bilateral mastectomies for fibrocystic disease.

We do not believe that hormone therapy has a useful place in the management of chronic cystic mastitis.

Bleeding Nipple

This often troublesome problem[4,31] may be briefly mentioned here since it is usually caused by an intraductile papilloma or papillomata, and this lesion, in turn, is often a part of the complex picture of fibrocystic disease. When bleeding from the nipple is associated with a palpable and discrete mass, biopsy, excision and (if the frozen section warrants) radical mastectomy are done. If the typical clinical picture of fibrocystic disease is present, the criteria of management are the same as those for that disease. Bleeding without cystic disease and without a palpable mass is treated with periodic observation.

Cancer of the Breast

We shall not discuss the pathological and clinical aspects of breast cancer[20-23,25] but shall limit these remarks to a summary of the methods of treatment used in our hospital. As regards the clinical features of carcinoma of the breast, it is earnestly to be hoped that they will soon become obsolete and that we shall see our patients with breast cancer so early in their disease that their diagnosis will depend entirely on the pathologist's report.

To assign the proper value to certain of the therapeutic measures in the management of breast cancer, it will be useful to cast a quick glance at some of the the recent results of cancer research.[15,29] Much of the most fruitful work in this field has been done on carcinoma of the breast in mice. The essential importance of genetic susceptibility has been established beyond reasonable doubt. A very striking new discovery has been the recognition of a factor, transmitted through the milk of the mother, that is necessary for the appearance of breast cancer in mice. This milk factor has many of the characteristics of a virus. Finally, it has been shown that the presence of estrogenic hormones is essential for the development of carcinoma of the breast in these animals.

It is inviting to translate these experiments into speculations about human cancer. A great deal of caution must, however, be exercised in any such attempt. The results of the animal experimenter are stimulating and useful in guiding the interests of the clinician toward promising lines of thought; it is a mistake, however, to transfer these results directly to human therapeutics. It is particularly important to remember that there is no reliable evidence that hormonal stimuli are the direct cause of malignant change in the human breast. Nor is there justification in advocating that, on the grounds of the experimental work with the milk factor, all women with a family history, however remote, of cancer should not nurse their infants.[11,18]

As to our criteria of operability of cancer of the breast, they can be stated simply. We advise radical removal of all breast cancer that does not have

distant metastases and that is not fixed to the chest wall.

The steps in our preoperative preparation are essentially the same for all breast biopsies regardless of the weight of evidence for or against carcinoma. The responsible relative of the patient is acquainted with the facts and possibilities of the case. It is he and not the patient who is told about the chances of a malignant tumor being present and the implications of this possibility. It is sufficient simply to point out the possible need for the removal of the breast. Operative technicalities to a layman are superfluous and often disturbing. Some general anesthetic agent is used and the patient is draped with the expectation that a radical operation may have to be done. Arrangements are made for blood transfusion during and after operation and for skin grafting. A pathologist is available for the rendering of a diagnosis on the frozen section of the removed tissue. The definitive form of treatment is not decided upon until the pathologist's report is on hand.

We have used exclusively the Halsted type of radical mastectomy in the treatment of breast cancer. We are quite convinced that none of the cardinal principles of this operation can be violated without the penalty of a lessened chance of cure. A wide skin incision that almost invariably requires skin grafting for closure; extensive dissection of the skin flaps close to the dermis; removal *en bloc* of the pectoralis major and minor muscles, of the sheath of the axillary vein, of the axillary content, and of the upper rectus sheath: all these are indispensable steps for the eradication of the carcinoma.

There is some disagreement as to the timing and effectiveness of x-ray irradiation.[10,16] Statistically, the advantages of irradiation in cases without axillary metastases are questionable.[13] Since, however, it is well established that metastatic spread is favorably influenced, and since no operation, however thorough, can claim to extirpate all the possible regional nests of cancer cells, the continued use of irradiation seems logical. We recommend irradiation in all cases of breast cancer, and we prefer to give the treatment postoperatively, starting the series as soon as the wound is healed.

In the past, inoperable cancer of the breast was treated with irradiation and possibly with a simple removal of an ulcerated neoplastic mass if such was present. Recently, hormonal therapy has been tried on the assumption that the estrogenic hormones of the ovary are cancerogenous. Two lines of attack have been evolved: (1) the disruption of the production of estrogens by castration either with the knife or with x-ray irradiation,[12,14,26] and (2) the neutralizing of these hormones by the administration of testosterone or allied substances.[2,8,28] Unquestionably, good alleviation can be obtained by either method. We have used testosterone propionate in conjunction with irradiation in a few cases and noted satisfactory response but only temporarily. The general trend of the results in published reports seems to be similar.

It may be mentioned that the artificial disruption of ovarian function has been tried out also as a routine auxiliary measure with radical surgery regardless of the state of advancement of the primary tumor.[14] The advantages of this audacious therapeutic step are not easy to see.

Before closing this brief review, we wish to mention that we consider *Paget's disease* as a true malignant neoplasm and treat it as such. A word should be said, also, regarding sarcomas of the breast.[1,9,19] These are rare tumors, and in our experience they are best managed in the same manner as carcinomas. There are, however, many advocates of treatment with simple mastectomy with or without irradiation.

Summary

The clinical characteristics of the commonest breast tumors are very briefly surveyed. The methods used in the Henry Ford Hospital for the management of these lesions, and especially of carcinoma, are outlined. It is stressed that every tumor of the female breast deserves and commands one's most earnest effort for diagnosis, for the diagnosis of all of these tumors must be regarded as the differential diagnosis of carcinoma.

References

1. Adair, F. E., and Herrmann, J. B.: Sarcoma of the breast. Surgery, 19:55-73, (Feb.) 1946.
2. Adair, F. E., and Herrmann, J. B.: The use of testosterone propionate in the treatment of advanced carcinoma of the breast. Ann. Surg., 123:1023-1025, (June) 1946.
3. Camphell, O. J.: Relationship hetween cystic disease of breast and carcinoma. Arch. Surg., 28:1001-1056, (June) 1934.
4. Camphell, O. J.: The bleeding nipple. Surgery, 19:40-46, (Feb.) 1946.
5. Clagett, O. T., Plimpton, N. C., and Root, G. T.: Lesions of the hreast. The relation of benign lesions to carcinoma. Surgery, 15:413-419, (March) 1944.
6. Cole, W. H., and Rositer, L. J.: Chronic cystic mastitis: with particular reference to classification. Ann. Surg., 119: 573-590, (April) 1944.
7. Davis, H. H.: Cystic disease of the breast; critical review. Surgery, 10:663-674, (Oct.) 1941.

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Nutrition and Infection

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STUDIES OF INFECTION during the past forty years have concerned themselves largely with the problems of the identification of specific organisms, variations in virulence, modes of transmission, and specific immune response — attention has been focussed on the organism. And yet the soil upon which the seed must be planted would seem to be of at least equal importance with the infecting agent. The experienced clinician has based his prognosis in a given disease as much on the nutritional state of his patient as on the type of organism with which he is infected. Numerous examples of what I have in mind will occur to anyone. The enteric disturbances of infancy which claimed such a heavy toll in the summer months did so only in that group of patients who were already poorly nourished. In a large service devoted almost entirely to the indigent infant under two years, an analysis of the previous histories of those who died in the summer months showed almost invariably that from a nutritional standpoint they had been undermining the resistance to what might have proved a relatively harmless infection, for at least six months before they became ill. Infectious diarrhea may occur in any economic stratum but its course will be determined by the previous nutritional state of the patient. Rheumatic fever and chorea are notoriously diseases conditioned by economic status, which in turn is the chief factor affecting nutrition. A good diet is relatively expensive; a poor one may be very cheap. In an outpatient clinic where I have worked for nearly twenty years, we have seen seventy-five cases of chorea. During that time there have been over a quarter million office visits, a large percentage of them supervisory checks of normal children born in the same institution. There was not a single instance of chorea occurring in the children whose nutritional state had been supervised. In that same institution during that time there were 225 cases of rheumatic fever and rheumatic heart disease admitted to the inpatient service among 15,639 admissions. Of these, sixty came from the extremely indigent group, orphans committed to the care of a foster home agency. Of the remaining, only seven had been seen previous to the development of the rheumatic state, and only two had been followed from birth. I have seen a moderate amount of rheumatic fever among well-cared-for patients in the office, but it has run a curiously abortive course, and my original poor prognosis on finding the condition has had to be revised an embarrassing number of times. Coburn contributes an interesting study on this point in a study of 100 children in New York City, half from the upper and half from the lower economic stratum. The notable deficiencies in the diets of the poor group were in protein, calcium, vitamins A and D, and iron. The correction of these defects in half the poor group led to a notable reduction in recurrences. Even the supplementing of the diet with eggs in a home for rheumatic children seemed to result in a failure of streptococcus infections to produce exacerbations in the rheumatic state. A similar observation was made at Christ's Hospital, London, when recurrences fell to one-third with an increase in the diet of milk and butter. This was attributed to the added fat, but this would seem gratuitous when those items likewise increased so sharply the intake of protein and calcium.

Cannon's studies along this line, that relate nutrition particularly to the development of an acute infection, stress the role of the serum globulins as the source of immune substances, and he sustains the thesis well that "any condition which affects protein metabolism either by leading to depletion of the protein reserves or by interfering with the adequate intake of high quality proteins may depress resistance (1) through the reduction in the quantity and quality of the phagocytic tissues, or (2) through its adverse effects upon the antibody mechanism."

In the tuberculosis field, the relation between an inadequate diet and increased incidence of the disease is almost taken for granted. Critical studies are difficult of evaluation, since mass dietary deficiencies are usually not separable from other socio-economic factors, such as housing conditions leading to increase in contact, and lessened medical care. Probably the study most often quoted is that of Faber in Denmark at the time of World War I. A 30 per cent rise in the mortality from tuberculosis occurred in 1916-17; a similar rise

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was noted in the belligerent counties and in Holland, which was continued until the end of the war. In Denmark, however, unlike these other countries, there was a prompt fall following a blockade which prevented the export from that country of foodstuffs, chiefly meats, fish, butter and probably milk—again items which were high in protein, calcium, fat and vitamin A. Our own studies are confined to this field and will be presented later.

In attempting to relate nutritional state to the occurrence or course of infection, our first problem is an adequate appraisement of nutrition. The weakness of simple measurements of height and weight is well recognized, though these become more worthwhile in children when the curve of growth over a significantly long period of time can be plotted in some such way as Wetzel suggested. Even so, gain in weight may be deceptively adequate over many months while basic substrates such as nitrogen and calcium are being lost to the body, and conversely, desirable losses in weight may be effected by the obese while nitrogen and calcium are being normally stored. One of the factors unfavorably influencing the storage of calcium and phosphorus, and thus increasing the possibility of rickets, is an increased speed of growth. We have used as our measure of nutritional status the retention of nitrogen and calcium as reflected in balance studies.

To clarify what follows, a few words may be appropriate about the laws governing the retention of nitrogen and calcium. Being basically structural substances, they behave quiet differently during the period of growth, the period of maturity and the period of senescence. The growth phase extends roughly through and is apparently limited by the attainment of sexual maturity, and since this varies a great deal, the measurement is physiological rather than chronological.

In the mature individual, increases in the intake of nitrogen do not result in its retention within the body unless there has first been created a deficit which requires filling; the normal picture is one in which intake and outgo are equal. In the growth period, retention quantitatively varies with the several spurts of growth, being extremely high in infancy and in the period just preceding the onset of sexual maturity. In the growth period, increases in intake will be accompanied by increases in retention only up to a certain point, beyond which the excess is rejected. In a general way, the metabolism of calcium follows that of nitrogen, though there are marked exceptions to this. Both are influenced by the entire endocrine system either directly or indirectly.

In general, the following major factors influencing retention have been studied, and some consideration given to their effect on the tuberculosis process: (1) diet, (2) vitamin D, (3) the endocrines, (4) the phase of growth, (5) infection, and (6 activity and rest.

First, as to the adequacy of the diet itself, we can speak from experience only in the case of children. We have measured this and feel definitely that the protein requirements particularly in the pre-puberty period is higher than commonly used —higher than recently recommended by the National Research Council; it proved in many cases to be 15 per cent of the total calories of an otherwise adequate diet, though 13 per cent did satisfy many, as judged by the nitrogen balance. The calcium requirement at this same period would be approximately 1.4 gm., or the amount represented by a quart of milk, an egg and average intake of vegetables.

Regarding the role of Vitamin D, excellent data are available to show the need for this in the period of infancy and childhood, but little effect was observed when growth had ceased. The further warning should be noted that, like thyroid, moderate doses may be anabolic while large amounts may reverse this. There is evidence that, again like thyroid, increases in the basal metabolism follow its use. The requirement during the period of accelerated pubertal growth would seem to be higher than that in the period of more stable growth. We have recently found in five cases of epiphysiolysis that a failure to store normally could be immediately corrected with an adequate intake of calcium and vitamin D, and that metabolically this condition was like infantile rickets though the blood did not reflect this. Histologically that condition is not like rickets.

Regarding the influence of the hormones, space will permit only a mention of possibilities. The growth-promoting factor of the anterior pituitary will increase storage but as yet has, in our hands, had no practical value since antihormone develops rapidly and prevents a continuation of any effect. In children, as opposed to adults, lowered metabolism referable to thyroid carries with it poor retention which can be improved by administering thyroid; but likewise,

abnormally elevated metabolism associated with toxic goiter also diminishes retention. Both of these phases of metabolism may occur as exaggerations of a normal physiological tendency to a pre-puberty rise and post-puberty fall, and should be watched for by the physician caring for the adolescent. In the girl at puberty, we have been able to show a definite depression with the estrogenic hormone, though it is reported that the reverse of this occurs in senescence. All of these findings merely emphasize the fact that there are at play a large number of glandular factors basically influencing nutrition quite independently of dietary intake.

The role of focal infection has been studied, and in the case of chronically infected tonsils a definite fall in basal metabolism, together with a marked improvement in the retention of nitrogen, followed tonsillectomy; in some instances the fore-period showed negative balances on an adequate diet, a fact which brings out graphically the importance of the detection and eradication of foci of infection in the promotion of optimal nutrition.

The story of the metabolic change incidental to sexual maturation when written in terms of metabolism brings out a striking depression of the retention incidental to the onset of menstruation in the girl. Considering growth patterns it might be expected that similar changes would occur in the boy several years later. Finally a comparison of retentions during rest and activity shows a striking fall in the ability to retain these items with bed rest, and that this state is definitely unphysiological, as Dock has so strongly stressed, and any advantages it may have should always be carefully weighed against its repeatedly demonstrated demineralizing effects.

To summarize this phase of the work, we have tried to point out a group of things which affect the storage of nitrogen and calcium, to make clear that this is not simply a question of securing an adequate intake of food but rather involves a consideration of a number of factors which can be brought out only by a thorough medical survey, which includes a good history and a complete physical examination. Dietary surveys fall considerably short of this.

Our studies attempting to relate nutrition as measured by the nitrogen and calcium balance have been made largely on two groups of children, one a group showing the first evidence of reinfection-type lesions, and the other well developed conditions under treatment. In the course of following regularly, for varying periods up to eighteen years, 1,100 tuberculin reactors removed from contact and placed in foster homes, wards of the Society of St. Vincent de Paul, we have found thirty-six reinfections, few of them advanced. These were hospitalized promptly and studies undertaken. When these healed without complication, the storages of nitrogen and calcium were high, so abnormally high in some instances that it could be understood only as a filling of depots which had been depleted by previous starvation. Several subjects showed a failure of storage for various reasons, and it was characteristic of these that healing did not occur, or even that frank spread of the process was evident. In one instance in which nitrogen was well stored, a reinfection lesion in the first two interspaces regressed slightly, but a fresh lesion appeared surrounding the old calcified Ghon tubercule. In this child, calcium was being lost for four months before this occurred. The commonest causes of an inadequate storage seemed to be (1) an underestimation of the requirement for growth and healing, (2) the metabolic changes incidental to puberty, and (3) intercurrent infection.

It is felt that these studies bring out a relation between nutrition, as measured by the nitrogen and calcium balances, and reinfection tuberculosis and its course.

Summary

1. In an eighteen-year study of tuberculin reactors removed from contact, endogenous reinfection was demonstrated in about 3 per cent of cases.

2. Balance studies suggested that the factor largely responsible for the development of the reinfection was a nutritional one.

3. The factors influencing an optimal retention of nitrogen and calcium for growth, and at the same time the integrity of the primary lesion, are manifold—dietary, infectious, glandular.

4. The provision of adequate stores for growth of these substances is likewise essential to healing of a lesion already developed.

Bibliography

1. Cannon, P. R.: Importance of proteins in resistance to infection. Implications of nutrition and public health in the post war period. Pp. 108-139. Privately published by the Children's Fund of Michigan, 660 Frederick, Detroit, Michigan.
2. Coburn, A. F., and Morre, L. V.: Nutrition as a conditioning factor in the rheumatic state. Am. J. Dis. Child., 65:744, 1943.

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Control of Virus Infections

By Thomas Francis, Jr., M.D.
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THE BASIC CONCEPT of control of infectious diseases, in general, lies in vaccinia-Jennerian prophylaxis as demonstrated in 1798. Here a virus, probably of modified nature, was shown to give rise to immunity against the more severe natural infection. It remains one of the most consistently effective of all vaccines, and because of this the idea has persisted that immunity in virus diseases is best induced by modified disease. In fact, this thesis persists in the general concept of immunization. For a considerable period it was believed that only by the use of active virus could immunity by vaccination be attained.

The notion was further enhanced by the Pasteurian vaccination against rabies. In that instance the virus of rabies was modified by passage through rabbits until it had reached a fixed stability of reduced virulence for the natural hosts and man. Under these circumstances, repeated inoculations of virus, graduating upward in activity, were employed for prevention of disease. The vaccine, owing to the prolonged incubation period of rabies, could be administered after the injury but before the onset of signs of infection. The limitations were that in injuries about the face the effect was less evident. In efforts to control the disease, vaccination of dogs was undertaken. The results were inconclusive, and the immunizing potency of the preparations was poorly established. In recent years, however, with increasing virus content of vaccines, even inactivated materials have with single injections in dogs proved to be effective in eliminating rabies in canine populations of several states.

Control of yellow fever had centered in the concept of eradication of the disease by elimination of the known vector, *Aedes aegypti*. In certain areas it was apparently accomplished. With the recognition of jungle yellow fever, a disease epidemiologically distinct from the clinical disease, in that it was not urban but jungle in nature, the problem enlarged. It was shown that monkeys and marsupials apparently could serve as the reservoir, and that species of mosquitoes living in tree tops served to transmit the disease. In the cultivation of virus in tissue culture, a spontaneous mutation was encountered, yielding a strain 17D. This strain no longer produced the characteristic disease in human individuals or in experimental animals. In the human, little or no evidence of disease was encountered, but the virus circulated in the blood and produced staunch immunity. This attenuated virus has been shown to be remarkably effective in the prevention of the natural disease.

The examples given all represent immunity induced by modified strains of active virus which produce subclinical disease and persistent immunity. The pattern has been followed in recent studies of immunization against distemper and cattle plague.

For a considerable time the concept was maintained that only by modified infection (active virus) could immunity be reduced. Early in the studies of influenza it was demonstrated that inactive virus could induce resistance to the active agent. Moreover, when given by routes other than respiratory, immunity was created. The studies which followed have demonstrated that virus cultivated in the embryonated egg can be inactivated by mild treatment while retaining the capacity to stimulate antibody production and immunity. In the extensive studies against influenza A, a distinct effect was obtained, and against influenza B the results were even more distinct. That the effect is not a permanent one is not surprising since the disease itself gives but a transient immunity. But the evidence points to a persistence of enhanced resistance for months; at least, probably extended to last over a respiratory season. It should be emphasized that this represents a clear demonstration of resistance induced by inactivated, noninfectious virus.

In animals, the equine encephalomyelitis virus and probably the Japanese B encephalitis virus appear also to be combated by the use of inactive virus vaccines.

Control of virus diseases has been largely limited to the application of prophylactic active immunization, because by the time the clinical symptoms of disease appear, the essential cellular injury has taken place. In recent years, however, two examples of prophylactic passive immunization against virus diseases have become clearly demonstrated.

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In measles the use of convalescent serum or of purified gamma globulin which contains the specific antibodies is well established. The point of interest in this passive immunological prophylaxis is that the effectiveness diminishes as one progresses from the time of exposure toward the onset of clinical disease. This deterioration in effect appears to parallel the development of the virus infection. If given early, even though the virus may have entered protective cells, the serum can prevent its transference to other cells and prevent the development of a sufficient bulk of infection to establish the disease; later, as the agent has become more diffusely entrenched in cells, the serum can serve only to modify or still later have no effect. The alteration in effect of immune serum seems to mark stages in the development of the virus disease.

In the past few years, Stokes and his associates have shown that infectious hepatitis (catarrhal jaundice) can also be prevented by the use of gamma globulin in the incubation period of the disease. When given in amounts of 0.08 to .15 c.c. per pound, it has been shown to prevent the disease if given six days or more before onset. Here, again, the preventive effect can be of great value in epidemics involving institutions or other closely associated groups. The effect seems clearly to indicate that the period of blood-stream invasion is an important stage in the pathogenesis of infectious hepatitis. The effect in serum jaundice with the prolonged incubation period has been less evident, but there are suggestions that repeated injections of antibody may have an effect here as well.

Therapeutic control of virus diseases has been of little significance except as it counters the secondary infections so common in measles, influenza, smallpox and others. There is one group of agents usually classified among the viruses in which, however, sulfonamides and antibiotics have shown consistent beneficial effects, experimentally and clinically. This is the psittacosis-lymphogranuloma group of viruses, characterized by elementary bodies, by carrier infection and by relapses. They are now classified as of the family Chlamydozoon. They are intracellular as are the other viruses but they have been shown to be susceptible to sulfonamides and penicillin. Psittacosis and ornithosis patients treated early and consistently with 200,000 or more units daily for several days after the fall of fever have been shown to respond well. Lymphogranuloma venereum has been less thoroughly documented but is also favorably influenced. The effect with these viruses indicates the probability that a therapeutic approach to virus infection is not as hopeless as has been commonly suggested. The response of agents such as those of tularemia, brucellosis, tuberculosis and other intracellularly disposed organisms may furnish a pattern for further advances upon the microbial midgets—the viruses.

MSMS

TUMORS OF THE FEMALE BREAST

(Continued from Page 562)

8. Farrow, J. H.: Effect of sex hormones on skeletal metastases from breast cancer. Surgery, 16:141-151, (July) 1944.
9. Geschickter, C. F.: Diseases of the breast. Second Edition Philadelphia: J. B. Lippincott Company, 1945.
10. Gratzek, F. R., and Stenistrom, K. W.: Roentgen therapy of mammary carcinoma: survival study based on 731 cases. Radiology, 44:44-57, (Jan.) 1945.
11. Gross, L.: Possibility of exterminating mammary carcinoma in mice by simple preventive measure; its practical implication for human pathology. New York State J. Med., 46:172-176, (Jan. 15) 1946.
12. Halberstaedter, L.: The artificial menopause and cancer of the breast. J.A.M.A., 131:810-816, (July 6) 1946.
13. Hoopes, B. F., and McGraw, A. B.: The Halsted radical mastectomy. Surgery, 12:892-905, (Dec.) 1942.
14. Horsley, J. S.: Bilateral oophorectomy with radical operation for cancer of the breast. Surgery, 15:590-601, (April) 1944.
15. Horsley, J. S.: Recent advances in the study of cancer. South. M. J., 36:8-12, (Jan.) 1943.
16. Lenz, M.: Tumor dosage and results in roentgen therapy of cancer of the breast. Am. J. Roentgenol., 56:67-74, (July) 1946.
17. Lewis, D., and Geschickter, C. F.: Endocrine therapy in chronic cystic mastitis. J.A.M.A., 109:1894-1900, (Dec. 4) 1937.
18. Macklin, M. T.: Human breast cancer and the milk factor. Science, 104:168-169, (Aug. 16) 1946.
19. Marshall, S. F.: Sarcoma of the breast. Surg. Clin. North America, 26:718-722, (June) 1946.
20. Marshall, S. F., and Forney, N. N.: Carcinoma of the breast: an analysis of 300 cases. Surg. Clin. North America, 26:723-729, (June) 1946.
21. McClure, Roy D.: A study of cancer of the breast. Tr. South. S. A., 44:372-382, 1931.
22. McClure, Roy D.: Tumors of the breast. Proc. Interest. Postgrad. M. A. North America, (October 17-20) 1944.
23. McClure, R. D., and Fallis, L. S.: Management of breast tumors. Canad. M.A.J., 52:14-19, (Jan.) 1945.
24. Nathanson, I. T.: The relationship of hormones to diseases of the breast. Surgery, 16:108-140, (July) 1944.
25. Oberhelman, H. A.: Diagnosis and treatment of carcinoma of female breast. Surg. Clin. North America, 26:116-129, (Feb.) 1946.
26. Orndoff, B.: Castration in malignant and non-malignant disease. Radiology, 42:159-163, (Feb.) 1944.
27. Patey, D. H.: Chronic cystic mastitis and carcinoma; collective review. Internat. Abstr. Surg., 68:575-579, 1939; Surg., Gynec. & Obst., (June) 1939.
28. Prudente, A.: Postoperative prophylaxis of recurrent cancer with testosterone propionate (androgen). Surg., Gynec., & Obst., 80:575-592, (June) 1945.
29. Shimkin, M. B.: Experimental induction of mammary cancer. Surgery, 19:1-24, (Feb.) 1946.
30. U. S. Department of Commerce, Bureau of the Census: Vital Statistics of the United States. Year 1944. Part 1, p. 10. Washington, D. C.: 1946.
31. Wakeley, C. P. G.: Duct papilloma of breast. Brit. M. J., 1:436, (March 31) 1945.
32. Warren, S.: Relation of "chronic mastitis" to carcinoma of the breast. Surg., Gynec., & Obst., 71:257-273, (Sept.) 1940.
33. Warren, S.: The prognosis of benign lesions of the female breast. Surgery, 19:32-39, (Feb.) 1946.

Prevention of Tropical Diseases

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EARLY CONCERN as to the possible spread of tropical diseases in America, and in the northern states especially, following the return of troops from tropical areas, now appears to be groundless in spite of a considerable number of recurrences of clinical malaria in veterans who contracted the disease during their war service. It appears that no secondary cases have developed, nor does it appear that there is any real cause to think that malaria will again be established in the northern states. Species of anopheline vectors present in this area are few in number, and those prevalent are not regarded as dangerous in their transmitting potentialities. It would further appear that there is no danger at all as to the establishment and spread of more strictly tropical diseases such as filariasis, kala-azar (visceral leishmaniasis), schistosomiasis or other diseases known to be of trematodal origin. Intestinal parasitism, although something of a factor in our troops serving in tropical campaigns, is scarcely to be considered at all, except in individuals who are still carrying large numbers of their parasites. Again, such instances indeed are quite rare.

The dysenteries, both bacillary and amebic, while generally considered as tropical problems, are nevertheless to be regarded as health factors throughout the world. In both instances, the carrier state very often becomes firmly established and may become a source of epidemic disease. Both bacillary and amebic dysentery have long been known to occur in temperate and even arctic parts of the world, but are too frequently missed in diagnoses because they are too often regarded as tropical or semi-tropical in their occurrence. It is indeed possible that some of the outbreaks of dysentery, whatever the exciting cause, might arise, or might have arisen, from returned veterans of tropical service.

The almost incredibly rapid forms of air transportation to and from tropical parts of the world necessarily are accompanied by a certain amount of danger as far as occurrence and spread of tropical disease is concerned. Fortunately the spread in Michigan is likely to be limited by the absence or near absence of the specific vector and by the high standards of American sanitation.

As far as travel in the tropics is concerned for business or for recreational purposes, it might be pointed out that the two commonest disease processes, malaria and the dysenteries, are preventable, first, by attention to mechanical protection from mosquitoes in the case of malaria, and, in the dysenteries, by the use of caution, as far as possible, in selecting articles of food and in the use of drinking water. Green vegetables in an uncooked state are still to be considered potentially dangerous in tropical parts of the world where the raising and handling of these articles is still on a primitive scale. Water supplies in tropical parts of the world are, for the most part, still unsafe. American methods of water purification are yet to be installed. The boiling of water for beverage purposes, although an unhandy procedure, is still the safest and best, and is to be preferred over any amount of treatment methods applied on a small scale.

Preventive vaccines, including typhoid, are in themselves no absolute guarantee of safety if one expects to visit tropical parts of the world, where certain diseases for which we have a vaccine are likely to reach epidemic proportions.

Much is made particularly of Asiatic cholera and the terrifying proportions it very often reaches in the Orient. India, China and Polynesia are constantly scourged by this disease, and while few cases ever occurred in American personnel, it is likely that its prevention was due to American sanitation and American cleanliness, rather than to American or British vaccine. To this might very well be added the resistance of the healthy American as compared to the undernourished and chronically diseased Oriental.

Typhus vaccine has proved highly effective against louse-borne typhus, although it is to be recalled that louse-borne typhus is not particularly a disease of the tropical parts of the world, but is more common to the temperate zones. However,

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in winter months the semitropical parts of the world have very often had large epidemics. At the same time, it appears that the same vaccine is effective also against flea-borne typhus, which is common in endemic form throughout the tropics. No vaccine, however, was developed during the war for so-called scrub typhus, which, before the end of hostilities, came to be regarded as Tropical Disease Enemy No. 2, and second only to malaria. Fortunately, scrub typhus is not a factor within cities and towns, but is only encountered in brush and jungle portions of the tropical world.

Whereas, yellow fever has practically disappeared and is said to exist only in the hinterlands of Africa and Brazil in the so-called jungle form, nevertheless, it is to be regarded as a great danger which, although quiescent at the time, might very well reach epidemic proportions, and without warning. The mosquito vector of yellow fever is present in very large numbers throughout the tropics where American methods of mosquito control are not employed. Unfortunately, other governments have neither the money, nor the energy to enforce such precautions as ours. In this connection, it is interesting to note that travellers to India, who, in the course of their journey expect to touch at Brazil and the central portions of Africa where yellow fever is still regarded as being endemic, are not allowed to land in India until the incubation period has elapsed since departure from the African or South American continent. The same is true for those who have been vaccinated against yellow fever, since the vaccine itself is a live virus, and, therefore, carries the threat of introducing the disease in mild form in a highly susceptible population where the mosquito vector occurs in an uncontrolled abundance. Needless to say, air travel to India through non-yellow fever parts of the world, namely, the temperate zones, does not require yellow fever vaccination prior to the trip, and if the traveler does not touch the yellow fever portions of Africa, the government of India will allow entrance without question in this regard. India has been successful over these many years in keeping yellow fever out of that vast reservoir of highly susceptible individuals, and the government of India means to prevent, if humanly possible, such a holocaust as would occur if yellow fever were ever introduced there.

Dengue fever and sandfly fever, both highly prevalent in the tropics, are preventable by protection from insect vectors of these two diseases and in no other way. Unfortunately, one has difficulty in going about his daily tasks or recreation encased in a costume suitable to withstand the assaults of *Aedes aegypti,* a daytime biter, and the nights are even more uncomfortable if one must try to sleep beneath a netting thick enough to keep out the various species of genus *Phlebotomus* which might be present. Fortunately, neither of the two diseases is fatal, although very often convalescence is long and uncomfortable.

One would do very well indeed to renew one's protection against smallpox well in advance of a sojourn into the tropics where this disease still occurs in a most vicious form. Indeed, there have been instances wherein vaccinia has failed wholly to protect against variola in tropical epidemics.

For the most part, inoculations for all the diseases preventable by inoculation in one form or another are either handled, or insisted upon, by immigration authorities and other officials connected with the handling of visas. These inoculations, however, must not be regarded as affording complete protection in any sense of the word against the prevention of disease, and the individual himself, or his physician, should certainly see that everything possible in ways other than vaccination is done in the way of protection.

One of the bacterial infections, or one that might indeed be complicated by virus, has not yet been mentioned, although it very often accounts for many tragic events in what was undertaken as a holiday. I refer to pneumonia. In the tropics, pneumonia strikes without warning, and very often for little reason as far as the individual is able to ascertain or understand. Not uncommonly the tropic sojourner overindulges himself in many ways, and is likely to suffer exhaustion and what really amounts to exposure when he least expects it. The result too frequently is a pneumonitis which in no way follows the classical pattern, nor yields too readily to the forms of therapy ordinarily successful in temperate parts of the world. Too little is known about pneumonia in the tropics. It seems likely that it is both a virus and a bacterial infection combined. In any event, it is very likely to be fatal within a matter of days after onset, and is to be highly regarded as a potential danger in any instance of its occurrence in the tropics.

Editorial

RUGGED INDIVIDUALS

AMERICA IS A GREAT country, one in which we take pride, and one where we would rather live than any other on this green earth. Such a trite statement! In all seriousness, what did make the United States a great and worthwhile home for a rugged and manly race of men?

Our fathers came to America in order to find freedom from restraint, in order to find a place where they could work as they chose, and could make as great a future for themselves as they were capable. Individual effort—individuals striving for more and greater opportunities—individuals doing the things that would make their lives and those of their families more abundant, more fruitful, and more expressive of content and well being.

Homes were made in the wilderness with the help of a few friends, or alone, depending upon one's own strong arms and determination to get ahead. Communities grew and thrived, and in the end came independence which was not given but was hard earned. There were such leaders as George Washington, Benjamin Franklin, Thomas Jefferson, Benjamin Rush, Alexander Hamilton, Abraham Lincoln. And during those formative years, men were ready to assume their responsibilities and to make their opportunities.

But years have rolled by, and we find that people are more interested in security. Security is much more important than opportunity. The ambition is so to plan that the future will take care of itself. There will be no worries. We shall be able to stop at some undefined place in our progress, sit back and have everything handed to us from that time henceforth. That may not be the exact line of thought, but that is the logical conclusion.

Senator Wagner, he of the Social legislation in Washington, has complained that the new Taft-Ball-Smith-Donnell Bill, S.545, does not provide free health care for the multitudes, but requires a means test for free care. Senators Taft, et al, on the contrary, have seen the vision of a great and free people who, if allowed and given an opportunity, will make their own way. These gentlemen have given us a measure whereby any individual who wishes may make his health services secure, because there will be non-profit or other plans working, and he can use them, if he wishes.

If the American people through Congress will avoid the sugar-coated "life of Riley" so glowingly displayed by propanganda of every sort and from the very fountain heads of government planners—if they will look into the past and ask what made us what we have been these many decades, they will surely follow the lead of men of the same calibre as those out of the past. Vision in planning our future health and welfare is just as important now as it was in the days when we were making the world's first great Republic.

That vision is still with us—there are still clear-thinking men who look to more progress, greater opportunities, and a more abundant life. Beware of false prophets. Wagner—Murray—Dingell—Falk—Altmeyer—Parran have all tried to force a philosophy upon our people which carries too much soothing syrup.

What we need is ambition, resolution, energy, valor, an unconquerable spirit, and the will to make our future for ourselves; not to have it rubber-stamped for us.

MICHIGAN POSTGRADUATE CLINICAL INSTITUTE

THE FIRST ANNUAL Michigan Postgraduate Clinical Institute was held at the Book-Cadillac Hotel in Detroit on Wednesday, Thursday and Friday, March 12, 13, 14, 1947, under the sponsorship of the Michigan State Medical Society, with the co-operation of the Wayne County Medical Society, the University of Michigan Medical School, the Wayne University College of Medicine, the University of Michigan Department of Postgraduate Medicine and the Michigan Foundation for Medical and Health Education, Inc.

This institute brought together for the first time six great organizations in the field of medical education and research, and in the most active form of a clinical postgraduate institute for the practitioners of medicine of Michigan and the surrounding states of Ohio, Indiana, Illinois, Wisconsin and Ontario. The total registration was 1,293. Of these, 1,082 were doctors of

medicine with 113 registered from states other than Michigan.

Three days of conferences, symposia and panel discussions were enjoyed. The entire program was given by our own Michigan men, many of them the younger and more active leaders. We have demonstrated that Michigan can lead in medical thought as well as in economic and sociological advance. The young teachers, brought to this conference, have set a goal that will be difficult to surpass in another year, but one that is a challenge which we shall attempt to meet.

Most of the talks and discussions were made from notes or slides, and were not presented as formal papers. Abstracts of most of them, as well as several of the complete papers, will be published in about two numbers of THE JOURNAL. The articles are grouped in this way in order to emphasize the importance of this institute, and to stimulate a repetition next year.

We are proud of this demonstration of ability, and of the men partaking.

THE SPASTIC CHILD

SEVERAL CLINICS held lately in Michigan regarding the spastic child, have called this unfortunate problem to the attention of parents and doctors who must care for and treat the condition. Until recently these children were cared for as they arrived, and in the only way possible, physicians doing what they could with the knowledge and facilities at hand. The cause of the disease was only partially guessed at, and the treatment mostly inadequate. Many children were institutionalized and seen as little as possible by their parents and relatives.

Many of these children were considered morons; others supposedly not bright; some never became able to care for their daily needs and necessities, and others never could walk or dress themselves. In addition to the physical handicaps of the spastic child, those who have had experience with a large number report that they have a greater degree of emotional vulnerability than from any other physical handicap. They are especially prone to sensitivity and easily hurt in their feelings. The spastic child becomes a severe problem to all concerned. Many of these children have normal or above normal intelligence. Some surprisingly become active and useful citizens.

But now they have come into their own, so to speak. We now know much of the problem and care, and we have some doctors who have made sufficient study to give good advice leading to the making of useful citizens. The numbers of these cases are appalling when reduced to figures, and present an argument for more study and more needed provision for advanced and suitable care.

Seven spastic births every year out of a hundred thousand persons is a number to demand attention. One of these children will not survive, but six children with birth palsies each year out of a community of a hundred thousand people is a figure just as impressive as the approximately equal appearance of poliomyelitis. These children, as a rule, are born with their affliction, instead of attaining a degree of growth before being stricken. That fact minimizes the shock, and has so far militated against demand for research and study, it being accepted that nothing could be done.

Modern study and knowledge, however, prove that much can be done to ward off the disease, and to help these children overcome their handicap. Some of them are going through school and college, some are graduating into the professions. Typewriters and other aids have worked wonders.

We have drives and studies for the care of poliomyelitis, cancer, tuberculosis, rheumatism, the crippled child. Will the next great movement be to solve the problem of spastic paralysis?

The Michigan Society for Crippled Children and its leaders are working along this line with much enthusiasm and hope of success.

ON THE RUN . . . . .

Because dicoumarol lowers the prothrombin level of the fetus it should not be given to pregnant women.

* * *

Calcium penicillin in wax and oil is responsible for allergic reactions in 5 per cent of patients in whom it is used.

* * *

Chances are 10 to 1 for recovery in myocardial infarction but 10 to 1 against recovery in dissecting aortic aneurysm.

* * *

Engorgement of neck veins with increased venous pressure may be due to congestive heart failure, cardiac tamponade or pulmonary embolism.

* * *

Acute pancreatitis may respond favorably to paravertebral block.

Selected by W. S. REVENO, M.D.

Detroit Physiological Society

Session of March 20, 1947

The Pharmacology of a Series of Compounds Structurally Related to Hydroxytyramine: An Analysis of Vasodepressor Action

A. M. Lands, Frederick Stearns and Co., Division of Sterling Drug, Inc., Detroit 31, Michigan.

The intravenous injection of epinephrine may cause a rise, a fall or a rise followed by a fall in blood pressure, depending upon the amount of drug injected. In order to better understand this dual action, a series of compounds structurally related to hydroxytyramine have been studied for their effect on blood pressure. The most effective vasoconstrictor is d,l-norepinephrine, being 1.3 more potent than d,l-epinephrine. The replacement of the N-methyl group of epinephrine by larger alkyl groups leads to a loss of pressor action. The depressor effects which may be elicitable with epinephrine are prominent when the N-alkyl group is -ethyl, -isopropyl, -sec.-butyl or -tert.-butyl. It is weak when the N-alkyl group is -n.propyl or -n.-butyl. Greatest vasodepressor action was obtained with the N-isopropyl homologue (Isuprel).

If the alcoholic hydoxyl is removed from the beta carbon of Isuprel, depressor action is greatly diminished; if converted to the corresponding ketone, depressor action is abolished. The removal of one or both hydroxyl groups from the benzene ring of Isuprel diminishes depressor potency. The structural requirements for vasodepressor action appear to be as specific as those required for vasopressor action.

Bronchodilator action was determined by lung perfusion and in unanesthetized guinea pigs exposed to histamine mist. Effectiveness as a bronchodilator corresponded to the effectiveness of the compound as a vasodepressor agent. Thus, norepinephrine is a poor bronchodilator and a good vasoconstrictor; Isuprel a good bronchodilator and a poor vasoconstrictor. Epinephrine is a more effective bronchodilator than nor-epinephrine but is less effective than Isuprel.

Comparable results were obtained on other smooth muscle organs relaxed by epinephrine. Thus, Isuprel will relax the isolated guinea pig ileum in a dilution of 1 part in 50 million, and the isolated rabbit uterus 1 part in 20 million. Similarly, these organs *in situ* are relaxed by Isuprel in intravenous doses of 0.1 to 0.5 mgm./kgm.

The N-alkyl homologues of epinephrine have comparatively low toxicity. In albino mice, epinephrine has an L.D. 50 to 4 mgm./kgm. by intraperitoneal injection whereas Isuprel has an L.D. 50 of 450 mgm./kgm.

A Substance Derived from Bovine Plasma Which Produces Leukopenia and Lowers Blood Pressure

M. Mason Guest, Robert C. Murphy, Arnold G. Ware, Stephen R. Bodnar and Walter H. Seegers, Department of Physiology, Wayne University, College of Medicine, Detroit, Michigan.

A protein, relatively heat stable to 90°C, has been derived from the euglobulin fraction of bovine plasma. When injected intravenously this substance produces a lowering of the blood pressure in the dog and guinea pig which approximates 40 to 70 per cent of the initial pressure. Recovery usually occurs within ten to fifteen minutes, but a secondary fall frequently ensues. If sufficient material is given an irreversible shock-like condition results.

Following the intravenous administration of the bovine plasma fraction the leukocyte count in the blood from the femoral artery and vein falls within two to three minutes to an average of 1/15 of the initial value. The decrease in white cells does not appear to be correlated with the fall in blood pressure. The differential pattern is usually reversed so that for a period of time the lymphocytes become much more numerous than segmented forms. Sedimentation rates and hematocrit values are not affected significantly.

In perfusion experiments this protein material causes the isolated turtle heart to stop in diastole, or if visible contractions continue, the cardiac output falls to or near to zero. Recovery occurs within two to three minutes if the substance is ejected from the heart cavities.

The tonus of smooth muscle of the rabbit in-

(Continued on Page 606)

TWO DISTINCTIVE PENICILLIN PRODUCTS

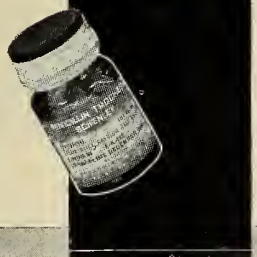
1

PENICILLIN TABLETS
Schenley

A special coating masks the penicillin taste of these tablets. Valuable in supplementing injections to maintain effective blood levels. Given in five times the parenteral dose, they may be employed to replace injections after the acute phase of the disease has subsided. Particularly useful in ambulatory cases.

Each tablet provides 50,000 units of calcium penicillin, buffered with calcium carbonate. Requires no refrigeration. Available in bottles of twelve.

2



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Michigan's Department of Health

Wm. De Kleine, M.D., Commissioner, Lansing, Michigan

MICHIGAN CANCER DEATHS INCREASE

Cancer deaths in Michigan increased 4 per cent in 1946 and have increased 17 per cent since 1940, according to provisional figures. There is an increase in cancer deaths among infants and children under ten, and an increase among people over forty. Almost 200 more males in Michigan died of cancer in 1946 than females. There is a decreasing trend in cancer deaths among females and an increasing trend among males. A contributing factor in the uptrend among males is lung cancer between twenty and forty-five years of age. Cancer, second cause of death, took 7,751 lives in Michigan in 1946, provisional figures indicate. One person in seven dying in the state, died of cancer; the national average is one in eight.

NEW HEAD AT RAPID TREATMENT CENTER

Fred O. Henker, II, M.D., arrived in Ann Arbor, April 5, to become medical officer in charge of the Michigan Rapid Treatment Center. Dr. Henker is a graduate of the University of Arkansas School of Medicine. He entered the United States Public Health Service and served at Marine Hospital, Baltimore, and at West Tennessee Medical Center, Memphis, where he did venereal disease work before coming to Michigan. He succeeds C. A. Smith, M.D., who has accepted a position with the University of Michigan Hospital.

RABIES ALARM IN SOUTH STATE

The incidence of rabies in Michigan has been increasing by more than one case a day for the past several weeks. A total of eighty-one cases have been reported to date this year. Five counties, Berrien, Kalamazoo, Van Buren, Cass and Monroe have established dog quarantines. The concentration of new cases in April are in Berrien, Kalamazoo and Van Buren, with a first case appearing in Jackson county. The county incidence of rabies this year follows: Berrien, 29; Kalamazoo, 14; Van Buren, 12; Wayne, 9; Cass, 8; Monroe, 3, and Jackson, Allegan, Genesee, Muskegon, St. Joseph and Shiawassee, 1 each.

X-RAY STATE EMPLOYES

A total of 1,812 employes and officials of the state of Michigan were given chest x-rays by a mobile unit of the Michigan Department of Health in March. The unit was set up in the Capitol and in the state office buildings.

URGE WHOOPING COUGH VACCINATION

The Michigan Department of Health, through daily and weekly papers and via radio, is urging vaccination of all children for whooping cough. A total of 2,882 cases was reported by April 4 in comparison with a seven-year median of 1,710 cases. Between 150 and 300 new cases are being reported each week.

NEW AID TO TUBERCULOSIS

The Michigan Department of Health has added a new medical social consultant in the Bureau of Tuberculosis Control to assist in co-ordinating the efforts of the Department and other state agencies into a concerted program of assistance to the patient and his family from diagnosis to full rehabilitation. Mrs. Jean Hansen, formerly rehabilitation director of the Ingham County Sanitorium and the Michigan Tuberculosis Association, has been appointed to the consultant's position.

NEW POLIO CASES

One case of poliomyelitis was reported in Wayne County during the week ending April 4; two cases, one in Wayne and one in St. Joseph County, were reported the week ending March 28.

VISITOR FROM INDIA

B. S. Yajnik, N.D., Director of the Provincial Hygiene Institute of Lucknow, India, on travel grant from the International Health Division of the Rockefeller Foundation, spent April at the Michigan Department of Health, studying its organization and techniques. Dr. Yajnik's fellowship study of laboratory production and diagnostic procedures in this country is aimed at improvement of the work of his laboratory in India. He requested his study at the Michigan Department of Health.

EVALUATE HEALTH SERVICES

The fifty-eight local health departments of the state have completed evaluation of their services to their respective communities. The summaries are now being submitted to the Michigan Department of Health and the field staff of the American Public Health Association for evaluation. Consultants of the health department are available to assist the local departments in improving their services and planning their immediate and long-range programs.

ADVISE IODIZED SALT

Through press and radio, the Michigan Department of Health is again urging the use of only iodized salt for cooking and eating purposes for the control of endemic goiter.

JOINS TB STAFF

J. R. Brown, M.D., joined the staff of the Bureau of Tuberculosis Control in March 17, on loan from the United States Public Health Service. Dr. Brown, a graduate of the University of Cincinnati, served his internship at Jewish Hospital, Cincinnati, before entering the Navy. He was stationed at an east coast tumor center and later loaned to the United States Public Health Service.

(Continued on Page 600)

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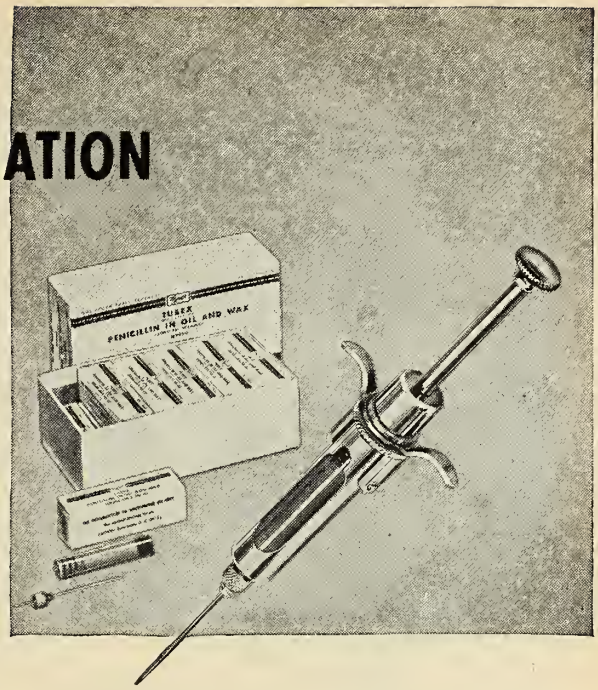

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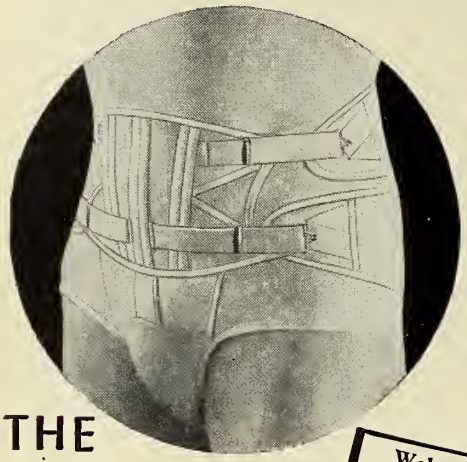

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Communications

L. Fernald Foster, M.D.
Secretary, MSMS
Lansing, Michigan

Dear Doctor Foster:

Permit me to thank you for the beautifully executed diploma of my emeritus membership in the Michigan State Medical Society, signed by you, the President and the Speaker. It is greatly appreciated.

The Society has progressed greatly in recent years. May it continue to prosper. Vivat, floreat, crescat.

Sincerely yours,
EMIL AMBERG.

February 13, 1947

Editor, Journal, MSMS

Dear Doctor Haughey:

Thank you for including my letter on tonsillectomy and poliomyelitis *in toto.* I also appreciate your editorial comments, and the data presented would seem to indicate that tonsillectomy should not be done at all; but I would rather think that at this stage it was a challenge to be more cautious in wholesale removal. I believe that tonsillectomy is indicated where necessary but not just for prophylactic purposes, and that I should have stressed in the letter which you published.

Sincerely yours,
FRANKLIN H. TOP, M.D.
Medical Director
Herman Kiefer Hospital

Wilfrid Haughey, M.D.
Editor, Journal MSMS

Dear Doctor Haughey:

I enclose a case history which to me seems interesting. It took me eighteen days to "come to" as to the cause of this baby's cyanosis. The case is timely in that the matter was dealt with in the November number of the *Journal of Pediatrics.* As a matter of fact, had I not seen these articles I most certainly would have missed the boat. Are there others?

Sincerely yours,
ROCKWELL M. KEMPTON, F.A.C.P., F.A.A.P.

Case History

Cyanosis of Twenty Days' Duration in an Infant Under One Month of Age, Responding to Methylene Blue Intravenously.

Baby M. S., aged two weeks, was brought to office, November 4, 1946, because the mother noted baby had been getting blue the past two days. Aside from cyanosis, examination was entirely negative. Weight 6 pounds 11 ounces. On formula of Pet milk, sterile water and Karo syrup.

A visit to the home November 5 revealed a two-

(Continued on Page 584)

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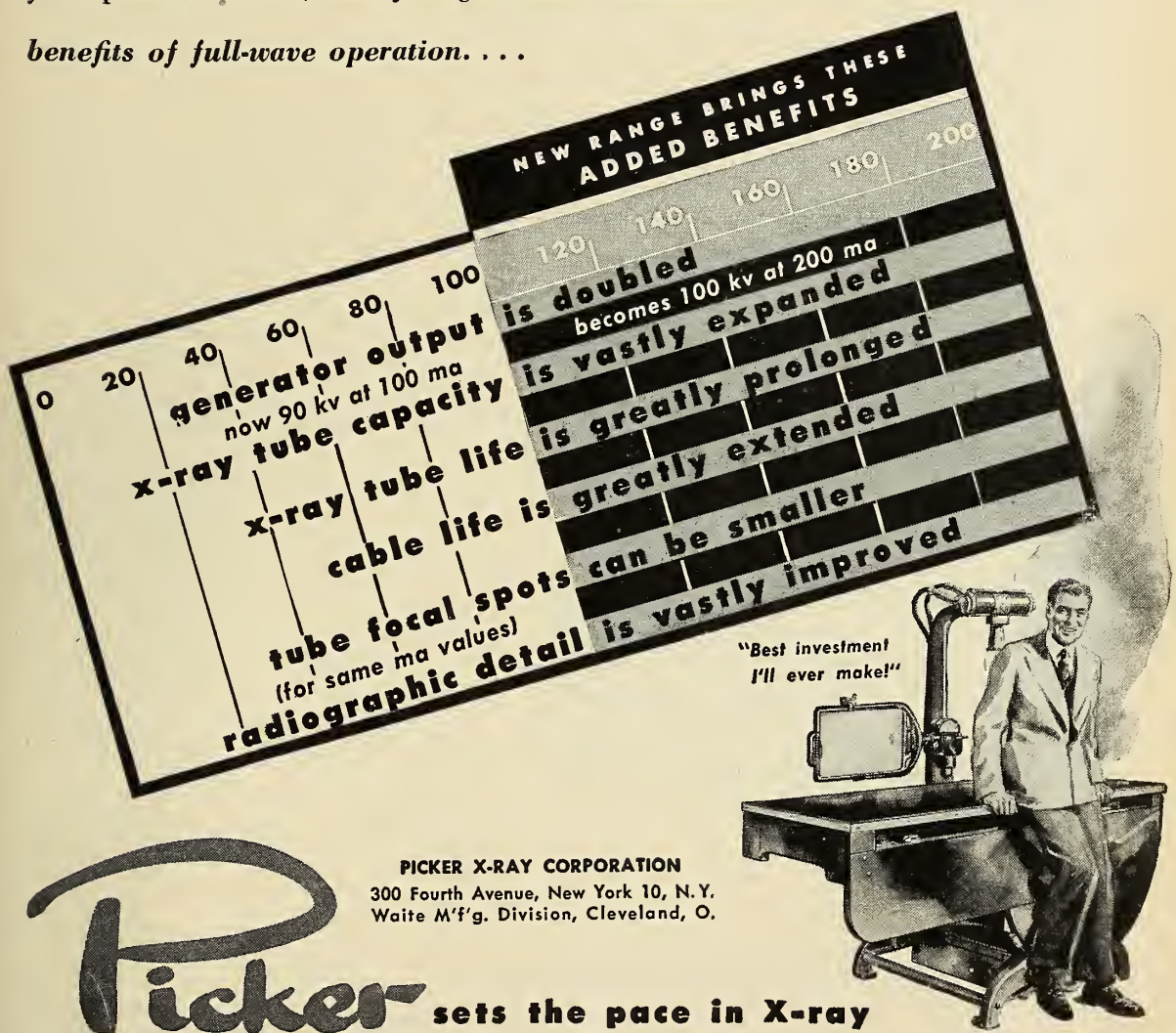

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(Continued from Page 580)

room apartment heated by a kerosene stove with no outside vent. The mother was advised to change the environment. The baby was moved to a furnace-heated apartment in the same house. The formula was unchanged.

No improvement in color a week later (November 13). The baby was very dusky and became markedly cyanotic when he cried. He also seemed to be in great distress with his bowels. Cramps were so severe that baby screamed with pain and it seemed impossible to give him relief. There was no vomiting and no diarrhea. Considerable distention was noted but enemas did not help. The parents felt there must be some bowel obstruction. Rectal sphincter seemed rather tight—dilated with little finger and glove. The formula was changed to Similac 1:2 made up in sterile water.

On November 21, on an emergency call to the home, the baby was found to be almost black and appeared dead. He was gathered up in blankets, rushed to the hospital, and placed in an oxygen tent, 50 per cent concentration. After five and one-half hours in oxygen, there was no improvement.

Twenty-four hours later (November 22, 9 a.m.) the baby seemed slightly more comfortable but was still deeply cyanosed. An injection of 0.6 c.c. 1 per cent methylene blue (aqueous) was made in the scalp vein. Within half an hour the cyanosis was almost entirely cleared and the baby was removed from the oxygen tent. At 8 p.m., eleven hours since the injection of methylene blue, the color remained good.

Color was still good November 26. Blood transfusion was given to correct mild anemia. The parents were instructed to use distilled water for the baby.

On March 17, 1947, the baby, now three and one-half months of age, was in excellent condition.

The probable cause of cyanosis was methemoglobinemia resulting from use of high nitrate-content-water in making up the baby's formula. In the rear of the house were two outside privies about seventy-five feet from the surface well pump.

Conclusions.—Shallow wells may contain nitrogenous waste. Sterilization of such water may kill all bacteria, but the nitrogen content remains unchanged and, in the presence of a certain bacterial flora in the infant's digestive tract, methemoglobin may be produced. Failure to produce symptoms and signs in the adult members of the family is to be explained on basis of the baby's fluid intake being relatively so much greater than that of the adult. An infant of a few weeks may be taking more than a quart of fluid daily, and many adults take little more than this. Note that when formula was changed to a dry milk the baby was getting 100 per cent contaminated water. It is interesting to note that as the cyanosis cleared, the abdominal distention and pain were relieved, suggesting that these symptoms were on the basis of anoxia.

As a practical point, if the water used in proportion of the formula is in question, it would be well to use a fresh cow's milk formula requiring only small additions of water.

Note—This case report was based on clinical observations unsupported by chemical tests on blood or nitrate content of water. For an excellent paper and complete bibliography dealing with subject, see J. Pediat., Nov., 1946.

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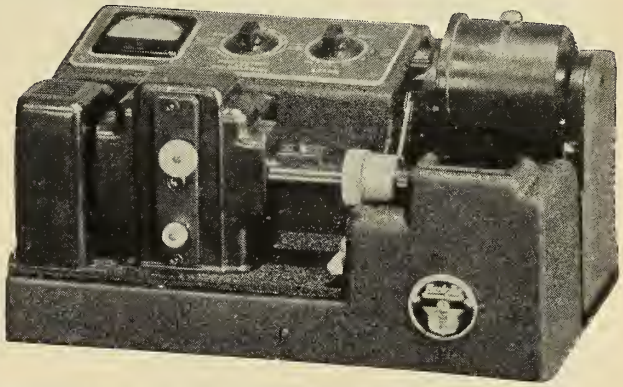

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* * *

According to Dr. Guillermo Diaz of Lima, Peru, there is but one doctor to 50,000 persons in Peru.

* * *

Fifty-six hundred veterans with certain disabilities received automotive conveyances at Government expense by the end of 1946.

* * *

The Third American Congress on Obstetrics and Gynecology will be held in St. Louis, September 8-12, 1947. For detailed information and the program, write 24 W. Ohio Street, Chicago 10, Illinois.

J. H. Ahronheim, M.D., Jackson, is the author of "Emotional Albuminuria in Combat" which was published in Psychosomatic Medicine, issue of January-February, 1947.

* * *

A nutritional survey is being conducted in Ottawa County under the auspices of the Ottawa County Health Department and the Nutritional Unit of the USPHS. The survey began April 2.

* * *

Renew your federal narcotic license on or before July 1, 1947. Send application blank and check to the Federal Narcotic Agent, Federal Bldg., Detroit, Michigan.

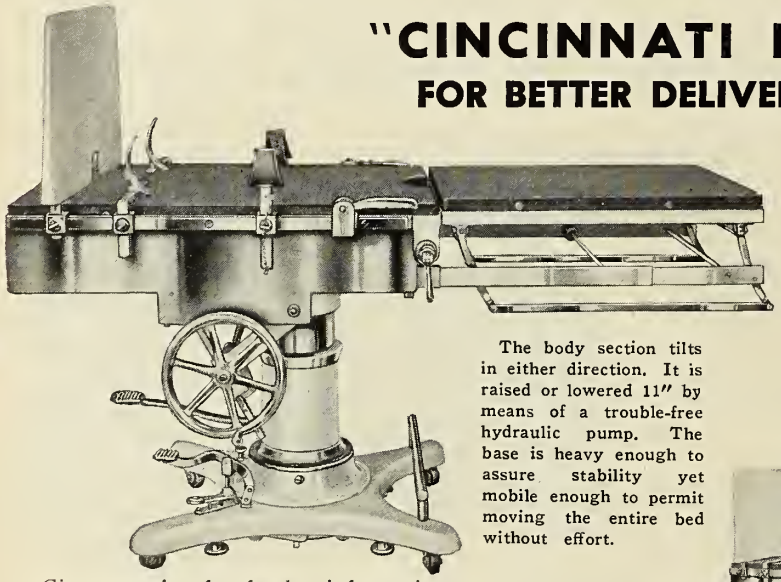
* * *

A commemorative stamp has been issued by the U. S. Post Office Department as part of the celebration of the 100th Anniversary of the founding of the American Medical Association. The three-cent stamp goes on sale June 9.

* * *

Governor Sigler has signed into law a bill requiring legislative review of all departmental rules. Under the plan any rule can be nullified by concurrent resolution and

(Continued on Page 588)



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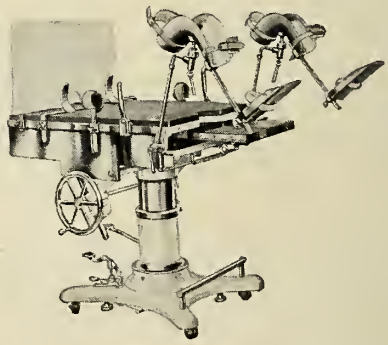

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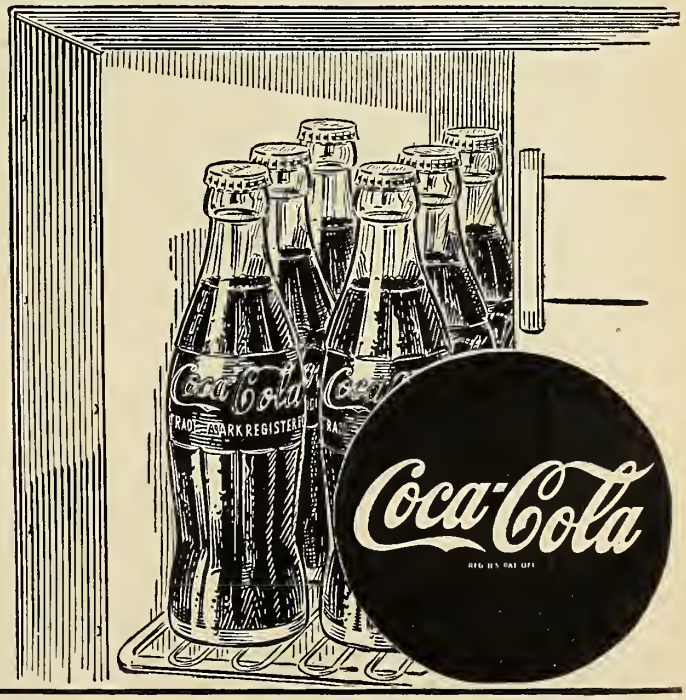

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(Continued from Page 586)

a joint legislative committee will meet between sessions to approve or suspend rules until the next regular session.

* * *

The National Gastroenterological Association will hold its 12th Annual Convention at the Chelsea Hotel in Atlantic City, N. J. on June 4-5-6, 1947. Program and further details may be obtained by writing the Association at 1819 Broadway, New York 23, N. Y.

* * *

J. W. Logie, M.D., Grand Rapids, has been appointed Chairman, and John M. Wellman, M.D., Lansing, is a member of the Committee on Scientific Exhibits for the 82nd Annual Session of the Michigan State Medical Society scheduled for Grand Rapids next September.

* * *

Henry R. Carstens, M.D.—Announcement of the marriage March 7, 1947 of Doctor Carstens, our former President, and Colonel in Command of General Hospital 17 in World War II, is received. The bride is Miss Coral Bremer of Philadelphia.

* * *

Doctor Wanted.—A. H. Catlin, Village President of Webberville, Michigan, a community of about 700 persons with a "good surrounding territory," writes that his village needs a doctor. There is no one nearer than six miles, and he is too busy to make calls at Webberville.

* * *

A. S. Brunk, M.D., Detroit, Past President of the Michigan State Medical Society, is the author of an article "The Work of the Conference of State Presidents" which appeared in the *Bulletin of the Association of American Physicians and Surgeons* for February, 1947.

* * *

"Chronic Liver Impairment" is an original article appearing in the March 29 issue of *The Journal of the American Medical Association* by John D. Mateer, M.D., James I. Baltz, M.D., Hugh H. Steele, M.D., Stephen W. Brouwer, M.D., and James R. Colvert, M.D., all of Detroit.

* * *

Frank VanSchoick, M.D., Jackson, Chairman of the MSMS Child Welfare Committee, was official representative of the Michigan State Medical Society at the State Meeting on Polio, sponsored by the National Foundation for Infantile Paralysis and held in Lansing on May 14.

* * *

President Wm. A. Hyland, M.D., Grand Rapids, addressed the Medical and Legislative Committees of the American College of Surgeons in Chicago on March 6. His subject was "A Program of Co-operation in Cancer Control Between the State Medical Society and the American Cancer Society."

* * *

Olin West, M.D., President-elect of the American Medical Association, resigned in April, because of ill health. Edward L. Bortz, M.D., Philadelphia, Vice-

Say you saw it in the Journal of the Michigan State Medical Society

President, will succeed Dr. West, and will be inaugurated as President at the Annual Session in Atlantic City in June.

* * *

"The Present and Future Role of the General Practitioner in Medicine" was the subject of an address by Wm. H. Marshall, M.D., Flint, at the regular general staff meeting at Hurley Hospital on April 18. The discussants were J. T. Connell, M.D., and Walter H. Winchester, M.D., of Flint.

* * *

The Shoe, Convalescent, Orthopedic, on which the Army opened procurement in January 1947, had its basic design contributed by Mr. Nathan Hack, Detroit shoeman, according to a press release from Colonel H. W. Bobrink, Commanding Officer of the Boston Quartermaster Depot.

* * *

The Jackson County Medical Society developed a three-page questionnaire listing "Vital Statistics" on each of its members, for the archives of the Society. For information and a sample of this very interesting blank, write Horace Wray Porter, M.D., Secretary, 505 Wildwood, Jackson.

* * *

Medicine and Industrial Research.—Mr. C. F. Kettering's paper on the above subject which was published in this JOURNAL in August, 1946, has been translated into Spanish and published in Revista de Radiologia y Fisioterapia, Enero-Febrero de 1947. We are pleased to receive a copy.

* * *

The Florida Medical Association has selected Ernest R. Gibson as Director of its newly created Public Relations Bureau. Mr. Gibson, who has lived in Florida two years, is a native of Ohio. While in the Navy, he served as Public Information Officer to the Commander of the Naval Air Training Base, Pensacola.

* * *

Senate Bill 215 in the Michigan Legislature would authorize osteopaths to make examinations for the commitment of the insane under the hospital act for mentally diseased persons. This is a further extension of the osteopaths into the field of medicine. Each little step like this leads to complete practice of medicine.

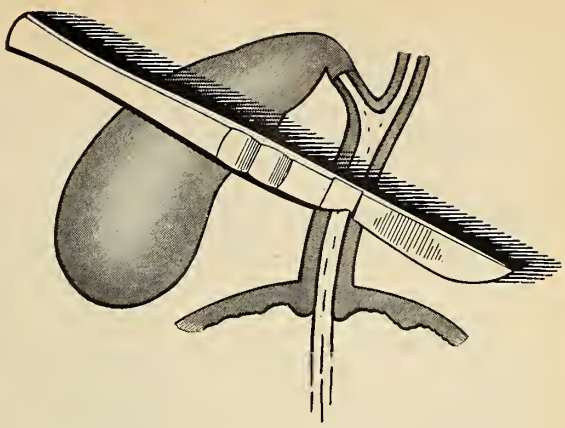
* * *

New Dates: Examination by the Michigan State Board of Registration in Medicine will be held at the Auditorium of the College of Medicine, Wayne University, Detroit, on Monday, Tuesday and Wednesday, June 9, 10, and 11, 1947. For further information write the State Board of Registration in Medicine, 202 Hollister Building, Lansing, Michigan.

* * *

Woman's Auxiliary.—Haddon Hall will be the headquarters for the Annual Meeting of the Woman's Auxiliary to the American Medical Association, which will be held in Atlantic City, New Jersey, June 9-13, 1947.

Requests for reservations should be sent immediately to Dr. Robert A. Bradley, Chairman, Subcommittee on Hotels, 16 Central Pier, Atlantic City, New Jersey.



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DETROIT 14 MICHIGAN

The Upper Peninsula Medical Society will hold its Annual Session at the Four Seasons Club, Pembine, Wisconsin, on Friday-Saturday, June 27-28, 1947. All members of the Michigan State Medical Society are cordially invited to attend. For program and reservations at the Club, write W. S. Jones, M.D., Menominee, Michigan.

* * *

The American Medical Golfing Association will hold its 31st Tournament at Atlantic City, New Jersey on Monday, June 9. Linwood Country Club and the Atlantic City Country Club both have been reserved for the 250 or more Fellows, who are anticipated will attend. Application blanks may be secured from AMGA Secretary Bill Burns, 2014 Olds Tower, Lansing 8.

* * *

The Upper Peninsula Medical Society Annual Session, to be held at the Four Seasons Club, Pembine, Wisconsin, Friday, Saturday, June 27-28, 1947, will present on its program F. A. Coller, M.D., Ann Arbor; C. G. Johnston, M.D., Detroit; Hardy A. Kemp, M.D., Detroit; M. Edward Davis, M.D., Chicago; Jack Gale, M.D., Madison, Wisconsin, and Robert Burns, M.D., Madison, Wisconsin.

* * *

Michigan Physicians Committee, a branch of the National Physicians Committee for the Extension of Medical Service, has the following officers: C. E. Umphrey, M.D., Detroit, Chairman; Wm. M. LeFevre, M.D., Muskegon, F. J. O'Donnell, M.D., Alpena, W. H. Huron, M.D., Iron Mountain, Vice-Chairmen; E. R. Witwer, M.D., Detroit, Secretary-Treasurer. The address of the Secretary is 3829 Brush St., Detroit 1.

* * *

S. 140 and S. 712 are an effort to place the Federal Security Agency in the President's cabinet, with the medical head of the health services subordinate to the social worker, or other non-medical individual. Those in general who advocated the Wagner-Murray-Dingell type of legislation are very active in testifying for these two bills. The best interests of the Medical profession, we believe, are in S. 545.

* * *

Wm. A. Hyland, M.D., Grand Rapids, President of the Michigan State Medical Society, addressed the New York Academy of Medicine on April 4 on the subject "The Michigan Health Plan." A spirited question and answer period, in which Senator H. Alexander Smith of New Jersey joined, resulted from Dr. Hyland's brief presentation of medico-economic activities in Michigan, which included a progress report on Michigan Medical Service.

* * *

Under the provisions of the Narcotics Drugs Import and Export Act, it is unlawful for a physician to carry narcotic drugs in his medical bag back and forth between the United States and Mexico and between the United States and Canada. Narcotic drugs found in the possession of a physician upon returning to the United States are seized and forfeited. Because of lack of knowledge of the law many physicians are caused embarrassment

(Continued on Page 592)

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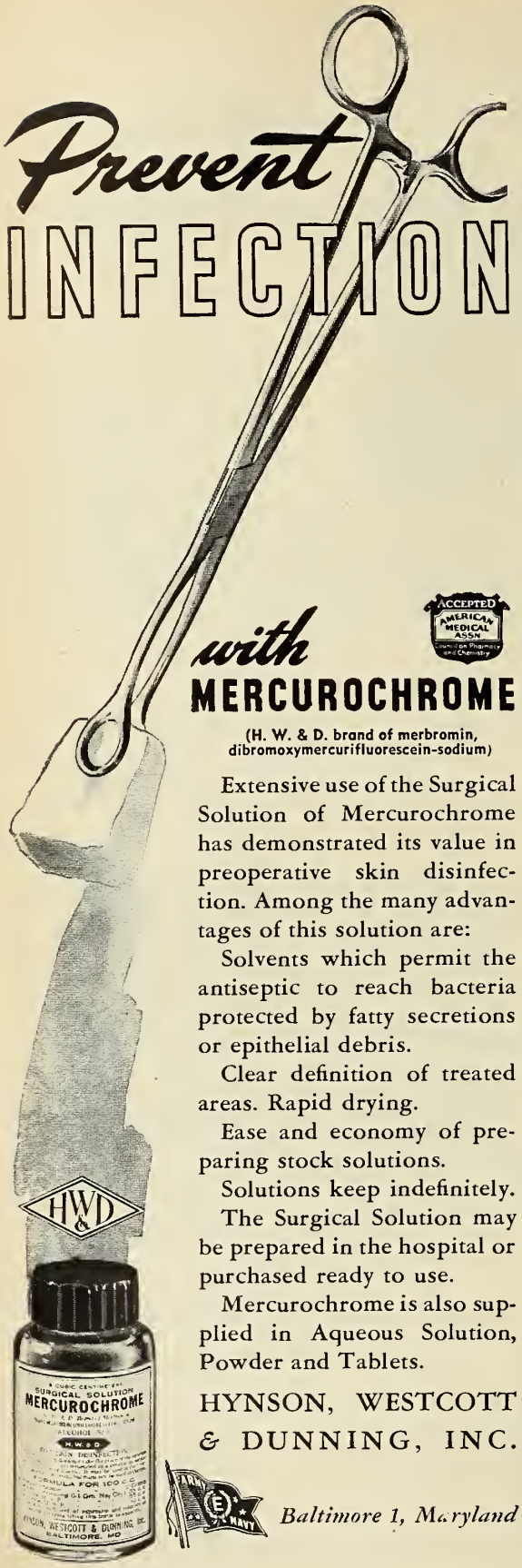

(Continued from Page 590)

and inconvenience when travelling between this country and Mexico or Canada. This information is published in order that physicians may be correctly informed with reference to this provision of the Federal law.

* * *

The AMA Council on Pharmacy and Chemistry has expanded its activities with a project operated by the Therapeutic Trials Committee which will be charged with the responsibility of aiding doctors of medicine with their research studies through a greater exchange of information. The value of planning co-operative research and disseminating the proper information is unquestioned. Through these means the medical profession will have at its command added facilities for supplying it with necessary information quickly and accurately.

* * *

The Genesee County Medical Society's Second Annual Cancer Day was a most successful postgraduate clinic, held at Flint on March 19. Speakers included Cornelius P. Rhoads, M.D., New York, A. C. Furstenberg, M.D., Ann Arbor, G. Gavin Miller, M.D., Montreal, George N. Papanicolaou, M.D., New York, David Steele, M.D., Cleveland, and Charles F. Kettering, Sc.D. of Detroit. W. Z. Rundles, M.D., President of the Genesee County Medical Society was toastmaster at the banquet in the Durant Hotel.

* * *

Harefuah, The Journal of the Palestine Jewish Medical Association, has been received. This is the foreign edition, published in Tel-Aviv, Palestine. There are four articles, "Sterility in Women," "Remittent Rural Fever," "Huet-Pelger Anomaly of the Nuclei of the Leukocytes in a Jewish Family in Palestine," and "Dermatitis Among Workers Employed in the Citrus By-Product Industry." These are all printed in English. Anyone who wishes may join the society by addressing an application to the Association 9, Yavneh St., Tel-Aviv.

* * *

Council and Committee Meetings

Rural Health Committee, April 9, Lansing
Uniform Fee Schedule for Governmental Agencies Committee, April 10, Detroit
Legislative Committee, April 10, Lansing
Executive Committee of The Council, April 16, Detroit
Mental Hygiene Committee, April 17, Detroit
Cancer Control Committee, April 18, Detroit
Executive Committee of The Council, May 13, Grand Rapids

* * *

Deduction for Medical Expense.—Mr. Morrison of Louisiana introduced in the House of Representatives a Bill, H. R. 2526, on March 12, 1947, which repeals the limit on deductions from income tax statements for medical and health services. The present limit is 5 per cent of the gross income. If this new bill passes it will make a real problem in bookkeeping for all doctors, hospitals, dentists and others. At the end of the

(Continued on Page 594)

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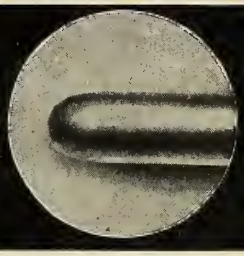

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(Continued from Page 592)

year all patients will be calling to know the total they paid each health service purveyor. Now it is necessary only when the amount is considerable.

* * *

Harry A. Pearse, M.D., Detroit and Alfred L. Chaput, D.D.S. of Royal Oak, recently returned from an interesting six weeks in Central America during which they visited the rugged highlands of San Pedro Soloma, Huehuetenango (pronounced Wa-wa-tenango), Guatemala. The six-day stay at Soloma represented a week of hard work for the two doctors who were prevailed upon by the local padre to create a "clinic" for the undernourished, primitive Indian people, wards of the mission. Doctors Pearse and Chaput were among the first white people ever to visit San Pedro Soloma.

* * *

College of American Pathologists, Inc.—Dr. Melbourne G. Westmoreland, Hospital Inspector, Council on Medical Education and Hospitals, is leaving A.M.A. the middle of April to become Executive Secretary of the newly organized College of American Pathologists, Inc. Headquarters will be in Chicago. Dr. F. W. Hartman, Pathologist, Henry Ford Hospital, Detroit, is President; Dr. Tracy B. Mallory of Boston, Secretary-Treasurer; Dr. Granville Bennett, University of Illinois, Vice-President and Dr. J. J. Moore of Chicago, a member of the Board of Governors.

* * *

"The National Conference of County Society Officers to be held at Atlantic City on Sunday, June 8, should serve a great purpose in informing the individual doctor what the American Medical Association is able to do for him as there are only a few states which hold an annual County Secretaries Conference such as is held in Michigan."—D. Bruce Wiley, M.D., Utica, Michigan, Michigan Chairman for the National Conference of County Society Officers.

Dr. Wiley invites all officers of Michigan County Medical Societies to attend the Conference scheduled for June 8.

* * *

Changing Age Averages.—Acccording to U. S. Census figures, and reliable estimates with respect to the future, the following figures represent the proportion of our population forty-five and sixty-five years and over at various dates:

Year	45	65
1860	13.1%	2.7%
1880	16.0%	3.4%
1900	17.8%	4.1%
1920	20.8%	4.7%
1940	26.5%	6.8%
1960	33.3%	10.0%
1980	40.3%	14.4%

* * *

U. S. Senator Robert A. Taft and Major General Paul R. Hawley of the Veterans Bureau have accepted invitations to speak at the Conference of Presidents and

(Continued on Page 596)

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(Continued from Page 594)

Other Officers of State Medical Associations, scheduled for the Ritz-Carlton Hotel, Atlantic City, N. J., on Sunday, June 8, 1:30 p.m. (the day preceding the opening of the Centennial Session of the American Medical Association).

L. Howard Schriever, M.D., Cincinnati, President-elect of the Conference of Presidents, will address the Conference on "A Medical Profession's Program to Improve Medical Care."

All officers and members of state medical associations are cordially invited to attend the annual meeting of the Conference of Presidents. No registration fee.

* * *

Wayne University Diplomas Available to Older Graduates.—Any graduate of the antecedent colleges of Wayne University who wishes to obtain a Wayne University diploma may now secure an application for such a diploma in the Alumni Office. The fee for the new diploma is three dollars ($3.00).

Degree holders of the Detroit College of Medicine and Surgery, Detroit Teachers College, College of the City of Detroit, Colleges of the City of Detroit, Detroit College of Pharmacy, and Detroit City Law School are eligible to request the Wayne diplomas; it is not necessary to turn in the original copy.

Many graduates have expressed regret that, although they are, in fact, Wayne University alumni, their diplomas do not so identify them.

The Kent County Medical Society has authorized its Program Committee to submit a plan to the resident staff of the three Grand Rapids hospitals whereby all interns and residents are invited to prepare papers of scientific or clinical interest on a subject of their individual choosing. The three papers most suitable for presentation will be heard by the Kent County Medical Society at a meeting to be known as "Residents' Night" annually in November.

Cash awards to the three successful contestants will be made, and the papers will be submitted for publication.

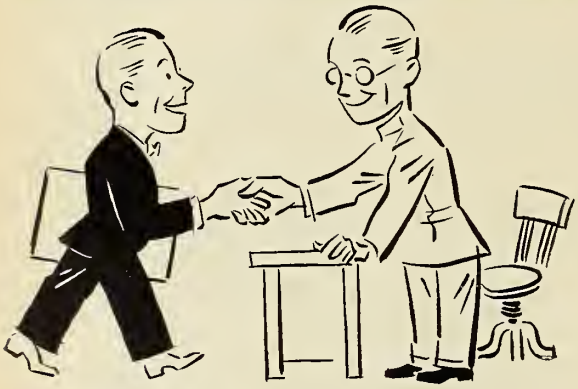
Congratulations, Kent County Medical Society, and may your worthwhile plan in postgraduate endeavor meet with success.

* * *

Industrial Health Speakers Roster.—The Committee on Professional Relations of the Council on Industrial Health of the AMA is setting up a roster of speakers containing names of doctors who can discuss the benefits of good industrial health services with groups of employes and the public. Some time ago the chairmen of state committees on industrial health were asked to suggest names of doctors to formulate this roster, and to date approximately 150 names have been received. The Council on Industrial Health will provide the material and guidance for the speakers.

Clarence D. Selby, M.D., Detroit, Chairman: Wm.

(Continued on Page 598)



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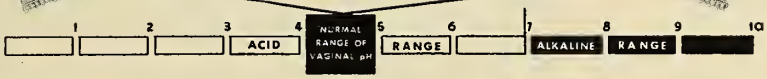

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(Continued from Page 596)

A. Sawyer, M.D., New York, and Anthony J. Lanza, M.D., New York, compose the Committee on Professional Relations. Dr. Harold R. Hennessey, Chicago, is executive officer.

* * *

Displaced Persons.—As a result of the war, and two years after its end there are 850,000 displaced persons in Europe living in detention camps. Of these 4,057 are trained nurses and 1,135 experienced hospital attendants. With our shortage of nurses and hospital attendants the Chairman of the Citizens Committee on Displaced Persons believes "it is a crime to allow these persons to literally rot in these camps."

H.R. 2910, sponsored by Rep. William G. Stratton, Jr., R. of Illinois, would allow an excess of immigration up to 100,000 each year for four years applicable to these displaced persons. This would still be under what the normal legal immigration for the past sixteen years would have allowed from these countries. 2,614,273 visas were available and fewer than 600,000 were used.

These persons are said to be 80 per cent Christian and 20 per cent Jews.

* * *

"Doctor of Medicine"—Radio Station CKLW—Fridays at 12:45 P.M. Prepared by the Michigan State Medical Society and sponsored as a public service by the Hack Shoe Company.

January 31—Edward D. Spaulding, M.D.—The Heart and Its Disorders

February 7—D. C. Beaver, M.D.—The Pathologist and The Patient

February 14—Francis F. MacMillan, M.D.—Common Sense Advice on Fractures

February 21—J. J. Lightbody, M.D.—Rheumatism and Arthritis

February 28—Charles S. Kennedy, M.D.—Gall Stones

March 7—W. S. Gonne, M.D.—Your Most Precious Possession—Your Eyes

March 14—Eugene A. Osius, M.D.—Varicose Veins

March 21—Ruth M. Kraft, M.D.—Children's Feet and Shoes

March 28—Harold C. Mack, M.D.—Change of Life

April 4—Clarence E. Umphrey, M.D.—Public Enemy Number One

* * *

Michigan has 5,103 practitioners of medicine in all ages, according to the Medical Mailing Service of Chicago. Those under 69 years of age total 4,902. Those in general practice total 2,860 of which 2,575 are under 69 years of age.

The breakdown of medical specialists in the United States, according to the same source, is as follows:

Allergists	349
Ear, Nose and Throat	1,791
Anesthetists	769
Bacteriologists	98

(Continued on Page 600)

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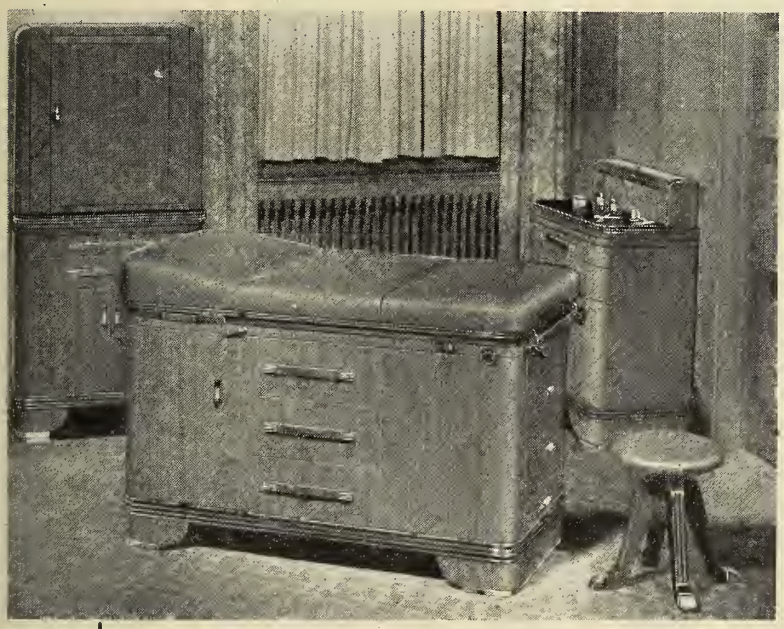

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MICHIGAN'S DEPARTMENT OF HEALTH

(Continued from Page 576)

ENTERS PRIVATE PRACTICE

George A. Sherman, M.D., Director of the Bureau of Tuberculosis Control, Michigan Department of Health, resigned effective March 1, to enter the practice of internal medicine in Lansing. Dr. Sherman, who came to the Department in February, 1941, is continuing to serve as director of the Bureau until his successor can be found.

INCIDENCE OF COMMUNICABLE DISEASE

Disease	March 1947	March 1946	7-year median
Diphtheria	22	42	25
Gonorrhea	884	1,083	813
Lobar pneumonia	166	75	279
Measles	263	13,527	3,306
Meningococcic meningitis	14	20	20
Pertussis	1,003	466	565
Poliomyelitis	3	2	1
Scarlet fever	769	689	1,326
Syphilis	1,412	1,478	1,373
Tuberculosis	614	438	489
Typhoid fever	4	5	5
Undulant fever	18	10	9
Smallpox	0	0	1

(Continued from Page 598)

Cardiologists	542
Clinical Pathologists	355
Dermatologists	1,354
Gastroenterologists	328
Gynecologists	856
Industrial Practice	1,708
Internists	5,712
Neurologists	155
Neuro-Psychiatrists	1,560
Neurological Surgeons	180
Eye, Ear, Nose and Throat	4,141
Obstetricians	2,138
Obstetricians and Gynecologists	4,135
Ophthalmologists	1,970
Orthopedic Surgeons	1,495
Pathologists	770
Plastic Surgeons	130
Pediatricians	4,208
Proctologists	723
Psychiatrists	1,033
Public Health	1,388
Roentgenologists	2,164
Surgeons	14,182
Tuberculosis	1,078
Urologists	2,232
Total:	57,544

* * *

The Eye Bank for Sight Restoration has been in operation for about a year. There was an article by Derrick Vail, M.D., Editor of the *American Journal of Ophthalmology* in June, 1946, on this subject. The effort is to collect healthy corneal tissue for transplanting to the eyes of persons who have lost their sight through corneal defects. Also the object is to train surgeons in the technique of this delicate operation. The public response to this stimulating and dramatic cause has been and continues to be strong and active. As more funds become available the influence set at work by the activities of the Eye Bank are certain to spread and result in much good to the cause of human welfare.

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Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

CARDIOVASCULAR DISEASES By David Scherf, M.D., F.A.C.P., Associate Professor of Medicine, New York Medical College, Flower and Fifth Avenue Hospitals; and Linn J. Boyd, M.D., F.A.C.P., Associate Professor of Medicine, New York Medical College, Flower and Fifth Avenue Hospitals. 56 Illustrations. Philadelphia: J. P. Lippincott Co., 1947. Price $10.00.

This text is one of the most important additions to the Medical Man's Library in the past few years. Former editions, which were favorably received and translated into seven different languages, have been completely rewritten, and much new, usable and authoritative information has been added.

Beginning with a chapter on dyspnea and ending with one on therapy, many previously omitted or lightly touched subjects are here covered in detail. Topics such as rheumatic fever, arteriovenous anastomosis, irradiation of autonomic reflexes, the cardiac neurosis and neurocirculatory asthenia, peripheral vascular diseases, hypertension, anginal pain and its differential diagnosis, the heart in endocrine disturbances, and cardiac disease in pregnancy are lucidly discussed.

The widespread incidence of myocarditis is again stressed and emphasized. The chapter on subacute bacterial endocarditis contains a detailed account of the current use of penicillin in this previous inevitably fatal condition. Another valuable addition is the attention given to roentgenology of the cardiovascular system in connection with the various subjects.

A few electrocardiograms are reproduced, but a detailed discussion is omitted as the authors' companion book on electrocardiography amply covers this field.

This authoriatative and detailed description of the cardiovascular disease can be recommended as a valuable addition to the physician's library and will be of marked aid in his practice.

RADIOLOGY FOR MEDICAL STUDENTS. By Fred Jenner Hodges, M.D., Professor and Chairman, Department of Roentgenology, University of Michigan; Isadore Lampe, M.D., Associate Professor, Department of Roentgenology, University of Michigan; and John Floyd Holt, M.D., Assistant Professor, Department of Roentgenology, University of Michigan. Chicago: The Year Book Publishers, 1947. Price $6.75.

Here is a handbook on radiology for students, entirely authored by our own University of Michigan teachers. It is clear, not controversial, and gives the essentials in the study of roentgenology for the medical student. It is not a complete text and does not intend to be, but is a very well-prepared guide for the undergraduate and the general man in medical practice. We are pleased to recommend this book.

MODERN DERMATOLOGY AND SYPHILOLOGY. By S. William Becker, M.D., Clinical Professor of Dermatology, University of Chicago, and Maximilian E. Obermayer, M.D., Clinical Professor and Chairman of the Department of Dermatology, University of Southern California. Second Edition. 461 Illustrations in text. 37 full-color plates. Philadelphia: J. P. Lippincott Company, 1947. Price $18.00.

This is a full sized textbook of over a thousand pages filled with the most complete and up-to-date information on the subject of dermatology. It is complete in detail

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and descriptions and contains pages of references for the student who wishes to pursue research. The illustrations are excellent and present the subject of dermatology through the only understandable method. Early in the book is a page of drawings giving the sixteen different kinds of skin lesions and their names, so references in the book will be understood. A long chapter is devoted to drug dermatoses, and another to physical dermatoses. Diseases due to filterable virus are given prominent space, and of course syphilis is extensively covered, including diagnosis and treatment. This is a most satisfactory volume for the student and the practitioner.

PROGRESS IN GYNECOLOGY. Edited by Joe V. Meigs, M.D., Clinical Professor of Gynecology, Harvard Medical School; Chief of the Vincent Memorial Hospital, the Gynecological Service of the Massachusetts General Hospital; Surgeon, Pondville Hospital; Gynecologist, Palmer Memorial Hospital, and Somers H. Sturgis, M.D., Chief, The Vincent Memorial Hospital Laboratory; Assistant Surgeon, Massachusetts General Hospital. New York: Grune & Stratton, 1946. Price $7.50.

This is a composite of short papers from seventy-one writers on the subject of Gynecology and its kindred branches. Everything new has been selected and included. The individual papers are reports of careful studies and research, brought together for the benefit of the practicing physician. It is impossible to point out specific subjects that will interest the reader, but the latest information on sterility, operative treatment of prolapsus uteri, et cetera, is here. This is a very interesting and instructive volume.

FUNDAMENTALS OF CLINICAL NEUROLOGY. By H. Houston Merritt, M.D., Professor of Clinical Neurology, College of Physicians and Surgeons, Columbia University, Chief of Division of Neuropsychiatry, The Montefiore Hospital; Fred A. Mettler,

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M.D., Ph.D., Associate Professor of Anatomy, College of Physicians and Surgeons, Columbia University; and Tracy Jackson Putnam, M.D., Professor of Neurology and Neurological Surgery, College of Physicians and Surgeons, Columbia University. Philadelphia: The Blakiston Company, 1947. Price $6.00.

The text of this book is divided into two parts. Examination of the nervous system deals with the examination of the cranial nerves, the motor system and the sensory system. Most of the book is devoted to anatomic diagnosis. This part is technical, tracing the anatomic causes of disease, the nerve lesions, the spinal cord lesions, tracts, and relations. Many pictures and diagrams are used. Cortical changes and areas and their effect on the health of the body are outlined. A handy book for fundamental studies in neurology.

PHYSICAL MEDICINE IN GENERAL PRACTICE. Edited by Arthur L. Watkins, M.D., Associate in Medicine, Harvard Medical School; Chief of Physical Medicine, Massachusetts General Hospital, etc. Philadelphia: J. B. Lippincott Company, 1946. Price $5.00.

Fourteen authors have contributed articles to this symposium, presenting the history and development of physical medicine, factors to be considered in prescribing physical methods; principles in treating dermatological conditions; minor injuries, fractures, and orthopedic disabilities. The author himself describes the uses of physical medicine in neurology. Physical and occupational therapy are well known in psychiatry, rehabilitation and employment. The uses of cold in surgery are well presented. All in all, this is a very interesting and instructive book.

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(Continued from Page 558)

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NATIONAL HEALTH ACT OF 1947

(Continued from Page 506)

VI. Further Research and Training (Title IX)

This portion creates an institute of Dental Research as a division of the National Institute of Health. The Institute shall have sufficient funds for its operation, and $2,000,000 is appropriated for new construction.

VII. Miscellaneous

There are outlined in Title III various legal technicalities, including changes in numbering of the various portions of previous Acts amended by this Bill.

Various references to administrative provisions appear in Sections 3, 105-109, 201-202, 715-718.

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Resigns as Protest Against Federal Encroachment in Health Departments

Roger E. Heering, Ohio Director of Health, submitted his resignation to Governor Herbert after the Ohio Legislature failed to appropriate more state funds for the Department so it would not be forced to use so much federal money for the operation of the Department. Between $700,000 and $800,000 of federal funds are being spent annually; of the 235 employes of Department's offices in Columbus, Ohio, 152 are being paid from federal funds, including the salaries of five division chiefs.

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(Continued from Page 572)

testine appears to be increased and the amplitude of contraction is greater when the strip is immersed in a solution of the protein substance, previously dialyzed against Tyrode's solution.

Effect of Methyl Testosterone on Calcium Metabolism in Growing Boys

Joseph A. Johnston, M.D., Pediatrician-in-Chief, Henry Ford Hospital, Detroit, Michigan.

Studies were made of the nitrogen and calcium balances of five boys aged seven, ten, ten, fourteen and fifteen years. Striking increases in the storage of nitrogen were noted but the calcium balance was consistently reduced, the losses being referable to an increase in stool calcium. The urinary excretions fell.

In interpreting an observation such as this, it should again be pointed out that among the many items conditioning the action of a hormone, one outstanding one will be whether or not the material administered supplies a defect or creates an excess; presumably it is the latter we were measuring. It is probable too that a different effect would result from the administration of androgens to the female; the subjects were all male. Finally, as in the case of divergent reports on the effect of estrogens on calcium retention, the age of the subject would be expected to play a role and it would not be surprising if quite different effects followed the use of this material in the aged.

NUTRITION AND INFECTION

(Continued from Page 565)

3. Faber, K.: Tuberculosis and nutrition. Acta. Tuberc. Scandinav., 12:287-335, 1938.
4. Johnston, J. A.: Factors influencing retention of nitrogen and calcium in the period of growth. III. Puberty in the normal girl with the minimal reinfection type of tuberculosis. Am. J. Dis. Child., 39:278-299, (Feb.) 1940.
5. Johnston, J. A.; Howard, P. J.; Smith, F. J., and Douglas, B. H.: Tuberculin reactors and exposure cases; follow-up study of cases removed from contact. Inquiry into endogenous reinfection. Am. Rev. Tuberc., 42:551-585, (Nov.) 1940.
6. Johnston, J. A., and Maroney, J.: Focal infection and metabolism; the effect of the removal of tonsils and adenoids on the nitrogen balance and the basal metabolism. J. Pediat., 12: 563-570, (May) 1938.
7. Johnston, J. A.: On the possible relation of nutrition to the development and course of tuberculosis. In: Tuberculosis in Industry by L. U. Gardner. New York: National Tuberculosis Association, June, 1941.
8. Warner, E. C.; Winterton, F. G., and Clark, M. L.: Dietetic study of cases of juvenile rheumatic disease. Quart. J. Med., 4:227, 1935.

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(Continued on Page 616)

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TYPICAL ANALYSIS

			Per Ounce
Protein	15.3%	Calcium	216 mg.
Fat	6.8%	Phaspharus	278 mg.
Carbohydrate	65.1%	Iran	6.6 mg.
Fiber	1.9%	Thiamine	0.33 mg.
Minerals (ash)	4.7%	Ribaflavin	0.051 mg.
	Per Ounce	Niacin	0.41 mg.
Calories	108		

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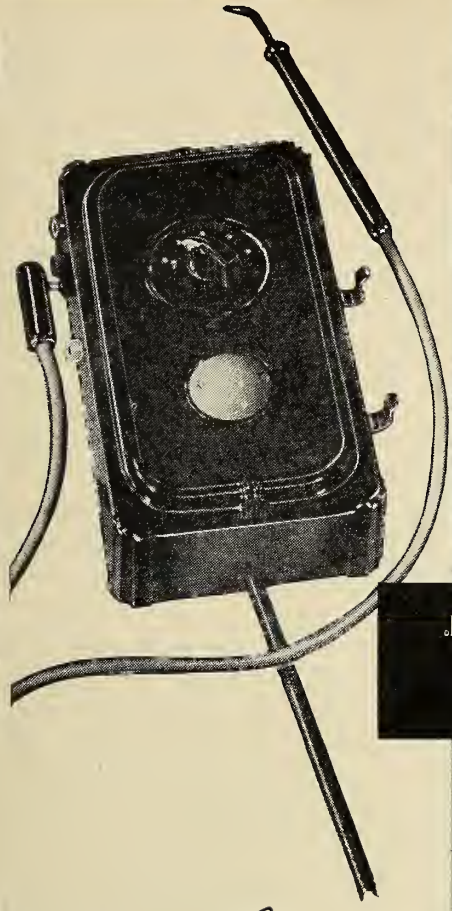

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MSMS 82ND ANNUAL SESSION

September 21 to 26, 1947, Grand Rapids

The 1947 Annual Session of the Michigan State Medical Society will be held at the Pantlind Hotel, Civic Auditorium, Grand Rapids, September 21 to 26.

Briefly the daily schedule is as follows:

Sunday, September 21, 1947
2:00 p.m.—House of Delegates, first meeting.

Monday, September 22, 1947
10:00 a.m. and 8:00 p.m.—House of Delegates, second and third meetings.

Tuesday, September 23, 1947
8:00 a.m.—Breakfast
9:00 a.m.—House of Delegates' fourth meeting

12:00 noon—Luncheon meetings of (a) Dermatological Section; (b) Radiological Section.

1:40 p.m.—Scientific Session and General Assembly, followed by Discussion Conferences at 4:30 p.m.

Wednesday, September 24, 1947
9:30 a.m. and 1:40 p.m.—Scientific Session and General Assemblies.
12:00 noon—Luncheon meetings of (a) Urological Section; (b) Pediatrics Section; (c) Surgical Section, and (d) Otolaryngological Section.
4:30 p.m.—Discussion Conferences.
8:30 p.m.—Officers' Night—Biddle Oration.

Thursday, September 25, 1947
9:30 a.m. and 1:40 p.m.—Scientific Session and General Assemblies.
12:00 noon—Luncheon meetings of (a) Anesthesia Section; (b) Ophthalmological Section; (c) Medical Section; (d) Gynecology and Obstetrics Section, and (e) General Practice Section.
4:30 p.m.—Discussion Conferences.
10:00 p.m.—State Society Night—Entertainment.

Friday, September 26, 1947
9:30 to 11:50 a.m.—Scientific Session and General Assemblies.
12:00 noon—Luncheon and meeting of Pathology Section, and luncheon Discussion Conferences in (a) Pediatrics; (b) Surgery, and (c) Medicine.

Officers' Night, Wednesday, September 24, will be a *public meeting* held in the Ballroom of the Pantlind Hotel, Grand Rapids.

State Society Night will be a social event of Thursday, September 25, also in the Ballroom of the Pantlind Hotel, Grand Rapids.

Members are urged to obtain their hotel reservations early—well in advance of September 1.

PROCEDURE FOR PRESENTATION OF SPECIAL MEMBERSHIPS

Adopted by the 1946 MSMS House of Delegates

WHEREAS, The presentation of candidates for special membership in the Michigan State Medical Society is ordinarily made by the various delegates, and

WHEREAS, The customary procedure of presentation of these candidates is time-consuming and repetitious, therefore, be it

RESOLVED, That a Committee of the House of Delegates be appointed to deal with all recommendations for special memberships, and be it further

RESOLVED, That all such recommendations for special memberships be presented to the chairman of this committee prior to the first meeting of the Annual Session of the House of Delegates for presentation *in toto* by the Chairman of this Committee at the Annual Session of the House of Delegates, and be it further

RESOLVED, That due and satisfactory notice of this procedure be given all secretaries of all county medical societies by information in the Secretary's Letters and by printed notice in THE JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY for two succeeding months prior to the Annual Session of the House of Delegates of the Michigan State Medical Society.

* * *

PROPOSED AMENDMENTS TO MSMS CONSTITUTION

Presented to 1946 House of Delegates for consideration by the 1947 House of Delegates

1. Re Life Membership:

WHEREAS, Article III, Section 8 of the Constitution of the Michigan State Medical Society, re "Life Members" does not adequately serve the best interests of the Michigan State Medical Society and does not confer upon its members the honor intended; therefore be it

RESOLVED, That Section 8 of Article III, of the Michigan State Medical Society Constitution be deleted.

(Continued on Page 622)

ITS DELICIOUS TASTE

is appreciated by the bland diet patient

Successful dietary restriction is possible only when the prescribed diet provides sufficient gustatory appeal to avoid monotony and drabness. Experience has shown that most patients find it difficult to subsist on foods which are "colorless" and largely tasteless.

Malt-o-Meal, an enriched farinaceous wheat cereal flavored with toasted malt, adds attractiveness and taste appeal to any bland diet. Its unique and delicious taste is enjoyed by all patients, hence this cereal can be eaten daily or more often if necessary. Malt-o-Meal is bland and residue-free (fiber content 0.4%). It is applicable whenever a bland, easily digested cereal food is required, as in peptic ulcer, colitis, dysentery, esophageal stenosis, dysphagia. In addition to the basic nutrients provided by wheat, Malt-o-Meal supplies significant amounts of thiamine, riboflavin, niacin, and iron.

CAMPBELL CEREAL COMPANY, Minneapolis, Minn.

Malt-o-Meal

Malt-o-Meal, an enriched wheat cereal flavored with toasted malt, provides per ounce (dry weight), 0.29 mg. of thiamine, 0.13 mg. of riboflavin, 1.09 mg. of niacin, and 2.00 mg. of iron. Thus Malt-o-Meal provides appreciably more thiamine, riboflavin, and iron than does whole wheat, and 78% of the niacin content of whole wheat.

PROPOSED AMENDMENTS TO MSMS CONSTITUTION

(Continued from Page 620)

2. Re Life Membership:

WHEREAS, Section 8 of Article III of the Constitution is originally intended to recognize period of service and membership in the Michigan State Medical Society and

WHEREAS, Section 6 requires fifty years in the practice of medicine regardless of attained age of the individual, and

WHEREAS, Ten years of membership, regardless of age, is a relatively short period of membership, therefore be it

RESOLVED, That Section 8 of Article III be amended to read: "A physician who has attained the age of seventy years or more and maintained an active membership in good standing for twenty-five years or more."

3. Re Emeritus Membership:

Amend Article III, Section 6, as follows:

Emeritus Membership—Any physician who has been in practice fifty years, or has attained the age of seventy years, and who has maintained a membership in good standing for twenty-five years, may, upon written application, and upon recommendation of his county society, and by election in the House of Delegates, become a member emeritus. A member emeritus shall be required to pay annual dues to the State Society not in excess of ten dollars and be relieved of paying all assessments. He shall be entitled to all the benefits and privileges of membership.

Delete Section 8 of Article III, which deals with life membership.

4. Re Life Membership:

Amend Article III, Section 8, as follows:

Life Members—A physician who has attained the age of seventy years or more and maintained an active membership in good standing for twenty-five years or more in the State Society may, upon his signed application, filed in the office of the State Society, and approved by his County Society at a regular or special meeting thereof, be transferred to the Life Members' Roster by election in the House of Delegates. He shall have the right to vote and hold office but shall pay no dues to the State Society. Requests for transfer shall be accompanied by certification by the Secretary of the State Society as to years of membership in good standing.

MMS REVISES APPENDECTOMY FEE

R. L. Novy, M.D., President of Michigan Medical Service, announces that at the meeting of the Board of Directors held April 30, 1947, the following Resolution was passed:

"RESOLVED that for all appendectomies performed on or after May 1, 1947, the fee be increased to $100.00."

This action increases the fee for appendectomies from $75.00 to $100.00. Based on 1945 experience figures, this will be an additional payment of benefits for subscribers of $161,000.00 per annum.

Have You Made Your

HOTEL RESERVATIONS?

MICHIGAN STATE MEDICAL SOCIETY

82nd Annual Session

Grand Rapids, September 23-24-25-26, 1947

The reservation blank below is for your convenience in making your hotel reservations in Grand Rapids. Please send your application to J. W. Logie, M.D., Chairman of Housing Committee, c/o Pantlind Hotel, Grand Rapids, Michigan. Mailing your application now will be of material assistance in securing hotel accommodations.

As very few singles are available, registrants are requested to co-operate with the Housing Committee by sharing a room with another registrant.

J. W. Logie, M.D., Chairman, Housing Committee,
Michigan State Medical Society Annual Session,
c/o Pantlind Hotel, Grand Rapids, Michigan.
Please make hotel reservation(s) as indicated below:

.....Single Room(s)

.....Double Room(s) for .....persons

.....Twin Bedded Room(s) for ....persons

Arriving September .....hour.....A.M.....P.M.

Leaving September .....hour.....A.M.....P.M.

(Names and addresses of all applicants including person making reservation).

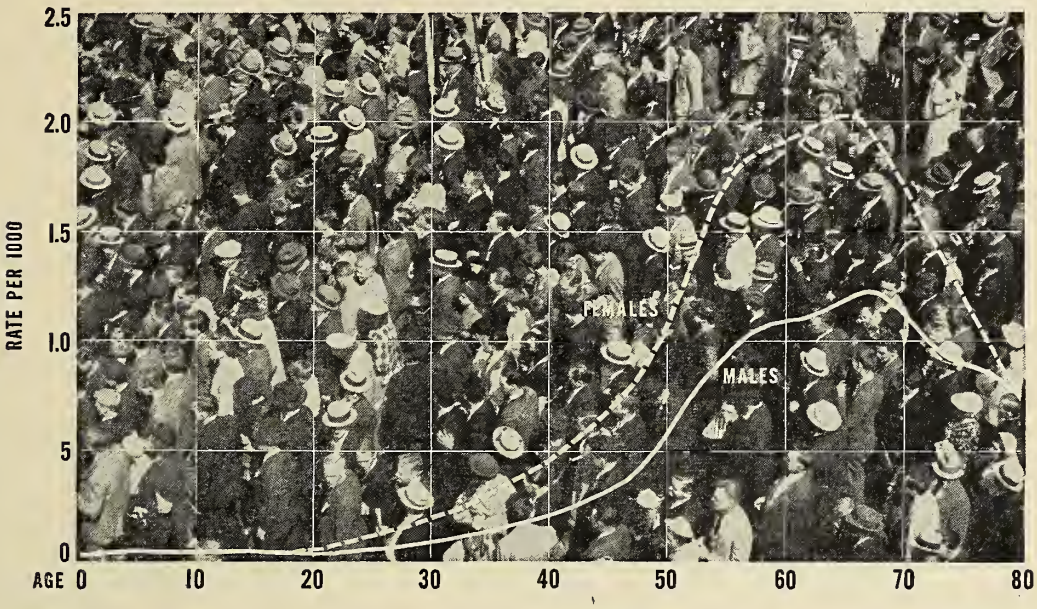
Name	Address	City	State

Date ..... Signature .....

Address ..... City.....

WITHIN THE YEAR: 50,000 *new diabetics*

CHANCES PER THOUSAND OF BECOMING DIABETIC WITHIN THE YEAR OF AGE. Adapted from Statistical Bull.[2]



Of our present population, about 4,000,000 will become diabetic sometime in their lives. More than 4% of females and 2% of males under 50 will acquire the disease. With an increase of 50,000 a year, their number will grow in the next few decades at a rate greater than that of the total population. When our population reaches its expected maximum in 1985, it will be 22% larger than in 1940—but by then the diabetic population may increase by 74%![1,2]

Control with but *one injection a day* of 'Wellcome' Globin Insulin with Zinc has been made possible for many diabetic patients who formerly required *multiple injections* of regular insulin alone or in conjunction with protamine zinc insulin. Favorable results with Globin Insulin have been achieved by virtue of the following advantages:

1. The action of Globin Insulin is *intermediate* between that of regular and protamine zinc insulin.

2. Its onset of action is moderately rapid; no accompanying injection of regular insulin is ordinarily required to take care of breakfast carbohydrate.

3. Maximum activity of Globin Insulin occurs during the day when the patient needs insulin most to balance carbohydrate intake. This contributes to a relatively uniform blood sugar level.

4. The action of Globin Insulin wanes during the night. Since the patient is not eating and has less need for insulin at this time, the danger of hypoglycemic night reactions is remote. However, adequate action persists up to the 24th hour so that a normal fasting blood sugar level is ordinarily obtained the following morning.

5. The globin constituent does not appear to be allergenic. It is thus comparable to regular insulin in its freedom from allergic reactions.

6. Globin Insulin is a clear solution which requires no mixing or shaking before use. The danger of variable dosage is thereby minimized.

'Wellcome' Globin Insulin with Zinc is available in 40 and 80 units per cc., in vials of 10 cc. Accepted by the Council on Pharmacy and Chemistry, American Medical Association. Developed in The Wellcome Research Laboratories, Tuckahoe, New York. U.S. Patent No. 2,161,198.

1. Spiegelman, M., and Marks, H. H.: Am. J. Pub. Health 36:26 (Jan.) 1946. 2. Statistical Bull., Met. Life Ins. Co. 27:6 (Feb.) 1946.

'Wellcome' Trademark Registered

'WELLCOME' Globin Insulin WITH ZINC

BURROUGHS WELLCOME & CO. (U.S.A.) INC., 9 & 11 EAST 41ST STREET, NEW YORK 17, N.Y.

National Research Council—Metopon

The Committee on Drug Addiction has sponsored the investigation of Metopon Hydrochloride and has offered the attached report. The contemplated plan of limited and controlled availability of the drug is based upon its narcotic character, its somewhat limited supply on account of manufacturing difficulties, and its advantageous applicability to the type of case indicated. The manufacturers, Mallinckrodt Chemical Works, Merck & Co., Inc., and the New York Quinine & Chemical Works, Inc., and the distributing pharmaceutical houses, Sharp and Dohme, Inc., and Parke, Davis & Co., have agreed not to advertise the compound, but to leave its introduction entirely to the profession. Under such circumstances, and to give our members every available knowledge, we are publishing the report in full.

Metopon Hydrochloride
(Methyldihydromorphinone hydrochloride)

In 1929 with the funds provided by the Rockefeller Foundation the National Research Council, through its Committee on Drug Addiction, undertook a co-ordinated program to study drug addiction and search for a non-addicting analgesic comparable to morphine. The principal participating organizations were the Universities of Virginia and Michigan, the United States Public Health Service, the Treasury Department's Bureau of Narcotics, and the Health Department of the State of Massachusetts, which brought together chemical, pharmacological and clinical facilities for the purposes of the study. Metopon is one of the many compounds made and studied in this co-ordinated effort.

Chemically Metopon is a morphine derivative; pharmacologically it is qualitatively like morphine even to the properties of tolerance and addiction liability. Chemically Metopon differs from morphine in three particulars—one double bond of the phenanthrene nucleus has been reduced by hydrogenation; the alcoholic hydroxyl has been replaced by oxygen; and a new substituent, a methyl group, has been attached to the phenanthrene nucleus. Studies made thus far indicate that pharmacologically Metopon differs from morphine quantitatively in all of its important actions—its analgesic effectiveness is at least double and its duration of action is about equal to that of morphine; it is nearly devoid of emetic action; tolerance to it appears to develop more slowly and to disappear more quickly and physical dependence builds up more slowly than with morphine; therapeutic analgesic doses produce little or no respiratory depression and much less mental dullness than does morphine; and it is relatively highly effective by oral administration.

In addition to animal experiments these differences have been established by extensive employment of the drug in two types of patients—individuals addicted to morphine, and others (terminal malignancies) needing prolonged pain relief, but without previous opiate experience. In morphine addicts, Metopon appears only partially to prevent the impending signs of physical and psychical dependence. Its terminal malignancy, administered orally, it gives adequate pain relief, with very little mental dulling, without nausea or vomiting and with slow development of tolerance and dependence.

The high analgesic effectivness of oral doses (with the elimination of the disadvantage to the patient of hypodermic injection), the absence of nausea and vomiting even in patients who vomit with morphine or other derivatives, the absence of mental dullness and the slow development of tolerance and dependence place Metopon in a class by itself for the treatment of the chronic suffering of malignancies, and it is for that purpose exclusively that it is being manufactured and marketed.

Metopon will be available *only* in capsule form *for oral administration.* The capsules will be put up in bottles of 100 and each capsule will contain 3.0 mgm. of Metopon hydrochloride. They can be obtained by physicians only from Sharp & Dohme or Parke, Davis & Co., on a regular official Narcotic Order Form, which must be accompanied by a signed statement supplying information as to the number of patients to be treated and the diagnosis on each. The drug will be distributed for *no other purpose* than oral administration for chronic pain relief in cancer cases.

The dose of Metopon hydrochloride is 6.0 to

(Continued on Page 626)

Experience is the Best Teacher

Herman von Helmholtz
(1821-1894)
proved it in ophthalmology

Although the inventor of the ophthalmoscope, Helmholtz's greatest contribution to medicine was his exhaustive researches on the mechanism of accommodation and the problem of color vision. The famous Young-Helmholtz theory of color vision resulted from his studies which confirmed and elaborated the findings of Young. His every work showed—*experience is the best teacher!*

Yes, experience is the best teacher in smoking too!

DURING the wartime cigarette shortage, people smoked many different brands—more than they would normally try in years. That's how so many learned the differences in cigarette quality. And from that experience millions more smokers came to prefer Camels. Today more people are smoking Camels than ever before.

But, no matter how great the demand, we don't tamper with Camel quality. Only choice tobaccos, properly aged, and blended in the time-honored Camel way, are used in Camels.

According to a recent Nationwide survey:

MORE DOCTORS SMOKE CAMELS

than any other cigarette

R. J. Reynolds Tobacco Co., Winston-Salem, N. C.

METOPON

(Continued from Page 624)

9.0 mgm. (2 or 3 capsules), to be *repeated only on recurrence of pain,* avoiding regular by-the-clock administration. As with morphine, it is most desirable to keep the dose at the lowest level compatible with adequate pain relief. Therefore, administration should be started with two capsules per dose, increasing to three only if the analgesic effect is insufficient.

Tolerance to any narcotic drug develops more rapidly with excessive-dosage and under regular by-the-clock administration. Also, as a rule, the pain of cancer varies widely in intensity from time to time. Pain, therefore, should be the only guide to time of administration and dosage level. Tolerance to Metopon hydrochloride develops slowly. It can be delayed or interrupted entirely by withholding the drug occasionally for twelve hours or for as much of that period as the incidence of pain will permit.

To each physician will be sent a record card for each patient to whom Metopon hydrochloride is to be administered. He will be requested to fill out these cards and return them in the addressed return envelope. He must furnish this record of his patient and his use of Metopon hydrochloride if he wishes to repeat his order for the drug. The principal object of this detailed report is to check the satisfactoriness of Metopon hydrochloride administration in general practice. The physician's co-operation in making it as complete as possible is earnestly solicited.

The limited use of Metopon hydrochloride as described above has been recommended by the Drug Addiction Committee of the National Research Council and the Committee with the co-operation of the American Cancer Society, will supervise the distribution of the drug. The Committee is composed of Wm. Charles White, Chairman, Washington, D. C.; H. J. Anslinger, Commissioner of Narcotics, United States Treasury Department, Washington, D. C.; Lyndon F. Small, National Institute of Health, Washington, D. C.; and Nathan B. Eddy, National Institute of Health, Washington, D. C. Queries and comments on Metopon may be directed to Dr. Eddy, who will answer them for the Committee.

References

1. Eddy, N. B.: The search for more effective morphine-like alkaloids. Am. J. M. Sc., 197:464, 1939.
2. Himmelsbach, C. K.: Studies of certain addiction characteristics of (a) dihydromorphine ("paramorphan"), (b) dihydrodesoxymorphine-D ("Desomorphine"), (c) dihydrodesoxycodeine-D ("Desocodeine"), and (d) methyldihydromorphinone ("Metopon"). J. Pharmacol. & Exper. Therap., 67:239, 1939.
3. Lee, L. E.: Medication in the control of pain in terminal cancer, with reference to the study of newer synthetic analgesics. J.A.M.A., 116:216, 1941.
4. Lee, L. E.: Studies of morphine, codeine and their derivatives. XVI. Clinical studies of morphine, methyldihydromorphinone (Metopon) and dihydrodesoxymorphinone-D (Dessomorphine). J. Pharmacol. & Exper. Therap., 75:161, 1942.
5. Small, L., and Fitch, H. M.: U. S. Patent, 2,178,010, (Oct. 31), 1939.
6. Small, L., Fitch, H. M., and Smith, W .E.: The addition of organomagnesium halides to pseudocodeine types. II. Preparation of nuclear alkylated morphine derivatives. J. Am. Chem. Soc., 58:1457, 1936.
7. Small, L., Turnbull, S. G., and Fitch, H. M.: The addition of organomagnesium halides to pseudocodeine types. IV. Nuclear-substituted morphine derivatives. J. Org. Chem., 3:214, 1938.

DOCTOR AND FRIEND, TOO

It took ten years for the American Medical Association to discover that the general practitioner, the "family doctor," is also a "specialist" occupying a front line position in service to the public.

There was strong opposition within the AMA to the formation of a general practitioners' specialty board to certify the qualifications of the family doctor, giving him equal honor with the specialists in his community and according him hospital practice privileges long denied.

* * *

The opposition was met by a persistent group of medical men of Michigan who were, themselves, "specialists," but who resented injustice and favoritism and realized that if the family doctor did not survive there was little chance that a free medical profession would survive.

The family doctor has come into his own. February 13, one hundred general practitioners met with a few of the old "war horses" who had carried the brunt of the fight in the AMA for the family doctor. They organized the Academy of General Practice of Wayne County, sanctioned, at last, by AMA.

* * *

It is the first organization of its kind in the country. It steps up the family doctor into his rightful place in the community and in the profession.

We foresee a rapid spread of this movement throughout the country with its great encouragement to young doctors, for virtually all doctors begin their careers as general practitioners, ready to tackle any ills.

They call in older and more experienced colleagues when needed, but they go on for years as family doctors, intimate friends, wise counsellors in many things besides physical ills, filling a basic need of every family in the land. —*Detroit News,* February 24, 1947.

lullaby...

without lament

There are many patients for whom you would like to prescribe the sweet, refreshing, untroubled sleep of childhood. To a large extent, you can accomplish this by administration of 'DELVINAL' *sodium vinbarbital*, a sedative that seldom causes excitation or "hangover." • 'DELVINAL' *sodium vinbarbital* provides sound, restful sleep, in the majority of instances, with relative freedom from unpleasant side-effects. A mild sedative, it exhibits a relatively brief induction period and a moderate duration of action. • 'DELVINAL' *sodium vinbarbital* may be prescribed for relief of functional insomnia, for general sedation, preanesthetic hypnosis, psychiatric sedation, obstetric amnesia, and in excitation states encountered in pediatrics. • Capsules: 30 mg. (½ gr.), 0.1 Gm. (1½ gr.) and 0.2 Gm. (3 gr.); Elixir, 0.25 Gm. (4 gr.) per fluidounce, in pint bottles. Sharp & Dohme, Philadelphia 1, Pa.

'DELVINAL'

Sodium Vinbarbital

SHARP & DOHME

Editorial Comment

FADING INK

The use of ink which does not fade and which is photogenic—that is, which is reproduced clearly in photostatic copies for all records where permanency is essential—is not a new subject. Insurance companies and departments of vital statistics have insisted for years on the use of black or blue-black ink in the filling out of application blanks or certificates. Such records are of a permanent nature and are photographed, in the case of birth and death records, sometimes years later.

The popularity of so-called ball-point pens equipped with long-lasting cartridges has brought to the fore the subject of the use of non-fading ink, which produces a smooth dark line, for important documents. Ball-point pens are manufactured by a number of firms. The inks in several brands of these pens were tested about a year ago by the National Bureau of Standards; all were found to fade quickly. Some manufacturers have been attempting to improve the ink used in these pens by adding compounds which are known to be light resistant. Tests have shown that writings made with these modified products have been found to leave a readable residue after exposure to a period of radiation equivalent to 100 hours of June sunlight. However, these improved inks are by no means in all pens.

The use of non-fading ink for physicians' records is of considerable importance. It was considered of sufficient importance by one clinic in Minnesota to justify the manufacture of its own ink for the past twenty years and the insistence on its use by all members of the group.

At the request of the Division of Vital Statistics of the Minnesota State Department of Health, the attention of the profession is called to the obvious importance of the use of non-fading, black or blue-black ink in filling out birth and death certificates.

—Editorial from *Minnesota Medicine,* April, 1947

A MOTHER AND HER BABY AND SCIENCE

This is a pictorial editorial. (Illustrated)

This picture was taken on Mother's Day, showing Mrs. Leonard Meyers and her seven-year-old son, Martin.

The little fellow was what the layman calls a "blue baby." His heart was so affected that he stumbled about helplessly, doomed to an early death.

In the medical profession this condition is called congenital cyanosis. The expression "blue baby" comes from the bluish tint of the skin due to its discoloration from deficient oxidation of the blood. This is brought about by a lesion of the heart at the time of birth.

Up to two years ago all such cases were considered hopeless.

Medical science knew of nothing that could save the child.

But scientific research found the way.

Now a very delicate operation is performed on the heart, the lesions are removed and the youngster quickly recovers to live the life of a normal child.

The pioneer in the work is Dr. Alfred Blabock, of Johns Hopkins University. The technique is being studied by the surgeons of the world. Hundreds have already learned it, many of them in Michigan.

Dr. Blabock alone has a waiting list of 800 patients.

There are thousands more who can be saved.

This tremendous advance in the art of healing came about through animal research in which the animals used suffer no pain.

We recommend this picture to the members of the Michigan Legislature who are being bombarded by well meaning but highly emotional men and women who are demanding laws curtailing this scientific research, on the strange ground that it is cruelty to animals.

They give to the word "vivisection" a monstrously wicked connotation.

All it means is cutting into living flesh (*vivius,* living; *secare,* to cut).

Every operation performed on a living human being is actually vivisection.

And since the dawn of scientific surgery millions upon millions of lives have been saved by it.

The great scientists in the field of medicine are servants of the human race.

Look at the joy on the faces of the mother and child pictured above, if proof be needed.

—Editorial from Detroit *Free Press,* May 13, 1947.

FLEXIBILITY

Pediatricians recognize the advantages of flexibility in prescribing infant feeding formulas, as the protein, fat, and carbohydrate requirement may vary with the individual baby. Formula preparation with CARTOSE* is simple, rapid, and accurate.

CARTOSE supplies carefully balanced proportions of nonfermentable dextrins in association with maltose and dextrose. Due to the time required for hydrolysis of the higher sugars, absorption is spaced. This lessens the likelihood of distress attributable to the presence of excessive amounts of readily fermentable sugars in the intestinal tract at one time.

When supplementation with vitamins of the B complex is indicated, KINNEY'S YEAST EXTRACT* is suggested for routine incorporation in the daily feeding. The full daily dose is simply added to the twenty-four-hour formula.

KINNEY'S YEAST EXTRACT is prepared from a specially cultured yeast and contains all the known factors of the B complex in natural, palatable form.

CARTOSE and KINNEY'S YEAST EXTRACT are offered for use under the guidance of physicians. They are available only at drugstores.

*The words CARTOSE and KINNEY'S YEAST EXTRACT are registered trademarks of H. W. Kinney & Sons, Inc.

H. W. KINNEY & SONS, INC. — Kinney trademark — **COLUMBUS, INDIANA**

Contributions and Pledges to Michigan Foundation for Medical and Health Education

Arthur C. Carlson, M.D., of Cottonwood, Arizona, recently contributed $500 to the Michigan Foundation for Medical and Health Education. Dr. Carlson is a past president of the Arizona State Medical Society who, some ten years ago, was honored by the University of Michigan for distinguished accomplishments; the University, at that time, conferred on him the degree of Doctor of Medicine, since Dr. Carlson was forced to abandon his medical studies in Ann Arbor a few months before graduation because of ill health, but continued his schooling and subsequently his practice in the Southwest.

Dr. Carlson, who has just erected a large modern hospital in Cottonwood, is a classmate and long-time friend of E. I. Carr, M.D., Lansing, President of the Michigan Foundation for Medical and Health Education.

* * *

Contributions and pledges to the Foundation from September 18, 1945, to June 1, 1947, are as follows:

Allegan County Medical Society	$ 85.
Anonymous	1,000.
Anonymous (Memory of Mother)	1,000.
Regis F. Asselin, M.D., Detroit	5.
R. H. Baribeau, M.D., Battle Creek	50.
Barry County Medical Society	50.
M. G. Becker, M.D., Edmore	1,000.
A. P. Biddle Estate	2,933.81
Branch County Medical Society	85.
C. D. Brooks, M.D., Detroit	1,000.
J. D. Bruce, M.D., Ann Arbor	1,000.
A. S. Brunk, M.D., Detroit	1,000.
Mary Lou Byrd, M.D., Grand Rapids	25.
A. C. Carlson, M.D., Cottonwood, Arizona	500.
E. I. Carr, M.D., Lansing	1,000.
H. R. Carstens, M.D., Philadelphia, Pa.	1,000.
L. G. Christian, M.D., Lansing	100.
R. E. Clark, M.D., Detroit	25.
B. R. Corbus, M.D., Grand Rapids	500.
Clinton County Medical Society	50.
C. V. Costello, M.D., Holland	1,000.
H. H. Cummings, M.D., Ann Arbor	1,000.
A. C. Curtis, M.D., Ann Arbor	15.
J. S. DeTar, M.D.	1,000.
Dickinson-Iron County Medical Society	80.
Eaton County Medical Society	70.
O. O. Fisher, M.D., Detroit	20.
A. C. Furstenberg, M.D., Ann Arbor	1,000.
L. J. Gariepy, M.D., Detroit	1,000.
Genesee County Medical Society	1,000.
Robt. W. Gillman, M.D., Detroit	1,000.
Gratiot-Isabella-Clare County Medical Society	125.
Grand Traverse-Leelanau-Benzie County Medical Society	167.50
T. J. Heldt, M.D., Detroit	25.
Lee Hileman, M.D., Ecorse	10.
Hillsdale County Medical Society	95.
L. J. Hirschman, M.D., Detroit	1,000.
L. E. Holly, M.D., Muskegon	1,000.
Houghton-Baraga-Keweenaw County Medical Society	140.
R. J. Hubbell, M.D., Kalamazoo	1,000.
Huron County Medical Society	55.
Wm. A. Hyland, M.D., Grand Rapids	1,000.
Ingham County Medical Society	1,572.50
S. W. Insley, M.D., Detroit	1,000.
Jackson County Medical Society	350.
Joint Committee on Health Education	1,000.
Francis Jones, M.D., Lansing	1,000.
F. H. Lashmet, M.D., Petosky	100.
Lenawee County Medical Society	125.
S. R. Light, M.D., Kalamazoo	100.
Macomb County Medical Society	130.
Manistee County Medical Society	200.
Marquette-Alger County Medical Society	135.
F. F. McMillan, M.D., Charlevoix	100.
Mason County Medical Society	35.
Mecosto-Osceola-Lake County Medical Society	45.
H. A. Meinke, M.D., Hazel Park	50.
Menominee County Medical Society	10,000.
Michigan Medical Service	10,000.
Mrs. K. B. Miner, Flint	1,000.
Monroe County Medical Society	145.
H. R. Moore, M.D., Newaygo	1,000.
H. L. Morris, M.D., Detroit	1,000.
Muskegon County Medical Society	310.
R. L. Mustard, M.D., Battle Creek	1,000.
Cora Boyce Neal, Grand Rapids	1,000.
Ontonagon County Medical Society	15.
Wm. H. Parks, M.D., Petoskey	100.
A. W. Petersohn, M.D., Battle Creek	25.
L. B. Rasmussen, M.D., Vicksburg	25.
Lawrence Reynolds, M.D., Detroit	1,000.
J. M. Robb, M.D., Detroit	1,000.
J. M. Robb, M.D., Detroit (Memorial to the late J. D. Bruce, M.D.)	100.
John Rodger, M.D., Bellaire	100.
G. B. Saltonstall, M.D., Charlevoix	1,000.
Sanilac County Medical Society	50.
C. A. Scheurer, M.D., Pigeon	30.
E. F. Sladek, M.D., Traverse City	5,000.
Ferris N. Smith, M.D., Grand Rapids	1,000.
St. Clair County Medical Society	220.
Shiawassee County Medical Society	1,000.
H. B. Steinbach, M.D., Detroit	100.
R. H. Stevens, M.D., Detroit	1,000.
C. L. Straith, M.D., Detroit	1,000.
R. H. Strange, M.D., Mt. Pleasant	1,000.
Jerrian VanDellen, M.D., East Jordan	100.
Ralph Wadley, M.D., Lansing	1,000.
R. V. Walker, M.D., Detroit	1,000.
Washtenaw County Medical Society	200.
H. L. Weitz, M.D., Traverse City	100.
C. G. Wencke, M.D., Battle Creek	10.
E. L. Whitney, M.D., Detroit	25.
S. B. Winslow, M.D., Battle Creek	50.
E. R. Witwer, M.D., Detroit	1,000.
Margaret H. Zalen, M.D., Kalamazoo	5.

(Pledge card on page 634)

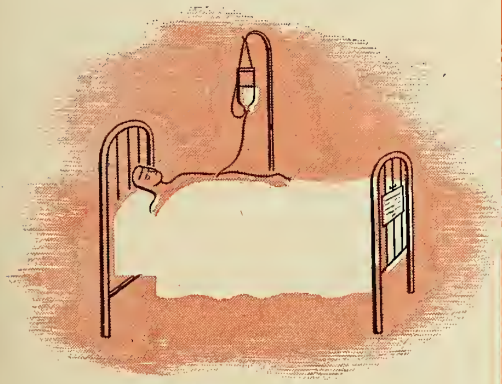
PREOPERATIVE

PREPARATION

"...the protein deficient individual is a poor operative risk."
Lund and Levenson: J.A.M.A. 128:95. 1945

"When time is available to improve protein nutrition before surgery and when this time is used efficiently for this purpose, the reduction in postoperative shock and other complications is impressive."

Editorial: Surg., Gynec. & Obst. 83:259. 1946



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Koop: Geriatrics 1:269. 1946

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Army Medicine

REPORT OF ATOMIC BOMB CASUALTY COMMISSION

A number of interesting facts relating to the Japanese who survived at Hiroshima and Nagasaki were disclosed in the report of the Atomic Bomb Casualty Commission.

The report carries no spectacular data or stories on freakism or physical anomalies among babies born to persons who were exposed to the bomb. It does not deal in the sensational. Based upon a study which was relatively short—about six weeks—the report simply gives a direct, unpretentious picture of work which is under way to evaluate the results upon human beings of a massive dosage of radiation, in combination with the heat and concussion generated by nuclear fission.

Following are some highlights of the commission's report, which was reviewed and cleared by the Atomic Energy Commission prior to issuance:

"Members of the commission have been impressed during their observations of atomic bomb survivors by the fact that many of the burns have healed with accumulations of large amounts of elevated scar tissue, the so-called keloids."

"The striking feature noted is the large number of burns that have healed with excessive quantities of scar tissue, having a relatively flat surface elevated above that of surrounding skin. Margins of these lesions are sharply defined. The area involved varies very much, some being as small as one centimeter in diameter while others may involve most of the face or the back. The maximum growth of such tissue evidently was reached about eight to ten months following the injury. . . . These are the so-called keloids."

"The assay of possible genetic effects is much more readily performed in plant and animal material than in man with, however, the important qualification that in man and, to a lesser extent, plant material, it is often impossible to be certain of position at the time of the bombing," says the report. "The Japanese efforts to utilize animal material have been completely nullified by the chaotic conditions and poor food situation."

Experiments with Drosophila fruit flies also had to be abandoned for lack of facilities and adequate testor stocks. With respect to plant material studies, the Japanese made certain observations purporting to show that vegetables grown in Nagasaki from seed from plants that were well beyond the known radius of bomb effects tended to assume unusual forms when grown near the ground center of the explosion. Dr. Takeo Furuno, noted horticulturist, maintained two experimental garden plots, one 150 meters and the other 500 meters from the hypocenter. Abnormal vegetative forms of Brassica chinensis, Lappa edulis, Cucuroita moschata, Solanum melongena and other species were reported to be far more frequent in the plot nearest the hypocenter, attributable to some effect of the atomic bombing on the soil.

"These two plots were inspected," says the Brues-Henshaw report, "and specimens of the vegetables examined. It was the opinion that soil differences complicate the picture to an extent where it is impossible to reach conclusions."

During the months of October and November, 1945, a study was conducted on 124 male inhabitants of Hiroshima. Examinations disclosed that, in 43 cases, the number of spermatocytes in the ejaculated sperm was less than 5,000 per cubic millimeter, or "absolutely sterile," in the words of Prof. Tsuzuki. Ten other cases were "relatively sterile" and the remaining 71 were normal.

"We have already clear evidence that the human sexual cells are also affected by the atomic bomb injuries. There is a possibility of malformation of the descendants, if the sexual cells should be affected selectively, without any severe damage to the other organs or tissues.

"In the survey of spermatocytes, it was noticed that they decreased not only in their number but they showed also some structural abnormalities. This problem must be, therefore, taken up and carefully followed further."

"Comparing the death rates of males and females, we find they are almost equal outside a radius of 1.5 kilometers from the ground center, but the rate of females within a radius of 1 kilometer seems to be lower than that of males. While we were staying at Hiroshima, we often heard that under the same conditions, men died more quickly, women were more resistant. We could not believe such a story at that time.

"But the statistics showed a result that in the central area, the female mortality seemed to be a little lower than the male. The reason for this fact is, of course, unknown. The central area, within a radius of 1 kilometer, was the place in which a tremendous number of neutrons reacted. We may be allowed to imagine that a difference of distribution of the atomic energies would cause the difference in the death rates between males and females."

VACANCIES IN ARMY MEDICAL CORPS

It is anticipated that there will exist in the Medical Department of the Regular Army 1900 vacancies in the Medical Corps, 370 vacancies in the Dental Corps, 10 vacancies in the Veterinary Corps and 440 vacancies in the Medical Service Corps.

Even though all of these vacancies in the Medical Department of the Regular Army could be filled, there will still be needed several thousand reserve component officers on active duty to meet the requirements in each and every corps of the Medical Department to fulfill the needs of the anticipated strength of the interim Army.

During the postwar period, up to the end of Selective Service, one-third of white registrants and nearly two-thirds of Negro registrants were rejected for physical and mental reasons. Out of every 1,000 inductees,

(Continued on Page 634)

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VACANCIES IN ARMY MEDICAL CORPS

(Continued from Page 632)

815 had one or more non-disqualifying physical defects—certain cases of hernia, uncomplicated venereal disease, dental and visual defects, et cetera.

Under a system of Universal Training, the Army can contract to receive the trainees, to improve within practical limits their physical and mental fitness, to provide them with excellent medical, dental and surgical care, and to guard their environment so as to control as effectively as possible common hazards to their health.

MEDICAL DEPARTMENT'S GRADUATE PROFESSIONAL EDUCATION PROGRAM UNDER WAY

Now well under way, but with a number of residencies and internships still open to successful candidates, is the Army Medical Department's graduate professional education program.

Primary objective of this permanent project is the provision to Army personnel of the most expert medical and surgical care possible. At the same time, it will offer hitherto unavailable opportunities to recent medical graduates, as well as licensed doctors who accept commissions in the Regular Army to qualify as specialists at an economic saving running into the thousands of dollars.

May 1 was the deadline for receipt of applications for residencies in nine military hospitals. Successful applicants will begin their duties on July 1.

At the present time, 182 Army medical officers are now undergoing residency training, 28 of whom are applicants for the Regular Army. Successful completion of this postgraduate instruction will furnish the formal training requirements necessary to enable them to take the American Board examinations for certification as surgeons, urologists, obstetricians, pediatricians, internists, et cetera. On the basis of the patient loads now being handled by the Army's nine approved teaching hospitals, 373 officer-residents can be accommodated—more than twice the number now in training. It is estimated that, for a peacetime strength of 800,000 men, the Army will require 573 certified specialists within the next five years; that is, 573 Medical Corps officers who are fully qualified as plastic surgeons, pathologists, radiologists, psychiatrists or in one of the other specialties or sub-specialties. At present only 82 members of the Regular Army Medical Corps are fully accredited specialists.

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Michigan Postgraduate Clinical Institute

FIRST ANNUAL MEETING—RECORD OF ATTENDANCE

(Continued from May issue)

Registration—March 13

Sidney Adler, Detroit; J. J. Angel, Wayne; R. M. Atchison, Northville.

Carl E. Badgley, An Arbor; Carl C. Bailey, Detroit; William A. Bailey, Detroit; Howard Baker, Detroit; O. F. Banting, Richmond; Louis L. Barnett, Detroit; Winona Barrows, Royal Oak; M. Baumer, Detroit; Clarence L. Becklein, Detroit; C. B. Beeman, Grand Rapids; E. G. Bellinger, Lansing; Clifford D. Benson, Detroit; Davis A. Benson, Detroit; K. A. Berkaw, Birmingham; W. G. Bernard, Detroit; Robert T. Blackhurst, Midland; L. F. Boddie, Detroit; William L. Bondel, Detroit; A. J. Bottsing, Byron Center; Walter H. Boughner, Algonac; A. B. Bower, Armada; D. R. Boyd, Muskegon; E. R. Breitenbecker, Detroit; G. M. Brown, Bay City; Richard J. Brown Owosso; A. S. Brunk, Detroit; James W. Bryce, Mt. Clemens; David C. Burnham, Detroit; John E. Burnett, Jr., Detroit; Julius N. Burnstine, Detroit; B. B. Bushong, Traverse City.

James E. Caraway, Wayne; Luther C. Carpenter, Grand Rapids; E. W. Caster, Detroit; A. E. Catherwood, Detroit; J. G. Christopher, Detroit; B. W. Clark, Detroit; T. Percy Clifford, Detroit; B. C. Clyne, Yale; Carl A. Coates, Dearborn; Daniel A. Cohn, Detroit; John P. Connally, Detroit; John J. Connors, Detroit; J. M. Cook, Lansing; Moses Cooperstock, Marquette; Wilfrid Cowan, Detroit; F. C. Cretsinger, Kalamazoo.

F. H. Darpin, Detroit; A. Jackson Day, Detroit; George A. DeJong, Detroit; Stella M. Delaini, Detroit; Alphonse R. Deresz, Detroit; J. S. DeTar, Milan; C. F. DeVries, Lansing; Edward K. Distler, Detroit; F. D. Dodrill, Detroit; Wendell R. Doering, Detroit; Harold T. Donahue, Cass City; John M. Dorsey, Detroit; Bernard J. Dowd, Kalamazoo; Aaron Dubnove, Detroit; Edmund J. Dudzinski, New Baltimore.

F. J. Eakins, Detroit; R. J. Elvidge, Detroit; Herman C. Emmert, Detroit.

J. D. Fagin, Detroit; S. G. Farbman, Detroit; S. P. Faunce, Detroit; L. E. Feldkamp, Detroit; E. W. Fitzgerald, Port Huron; Thomas E. Fleschner, Birch Run; Geo. A. Ford, Detroit; J. R. Forsythe, Detroit; Silvio P. Fortino, Lansing; L. Fernald Foster, Bay City; H. M. Fox, Portland, F. Bruce Fralick, Ann Arbor; J. Courtney Fremont, Detroit; Burl Frost, Detroit; Herbert S. Fuller, Detroit; H. T. Fuller, Mt. Morris.

L. Galdonyi, Detroit; Cyrus B. Gardner, Lansing; L. W. Gatley, Pontiac; I. S. Gellert, Detroit; Roy R. Gettel, Kinde; W. A. Gift, Marlette; Weldon A. Gift, Marlette; James L. Gillard, Detroit; P. C. Gittins, Detroit; Wm. A. Grant, Milford; Morris Z. Greenberg, Detroit; B. F. Glowacki, Detroit; V. P. Goodman, Lansing; Cloid D. Green, Detroit.

E. W. Hall, Detroit; James A. J. Hall, Detroit; Brenton M. Hamil, Detroit; A. J. Hamilton, Flint; Kuno Hammerberg, Clare; Fordus V. Hand, Detroit; George E. Hardy, Detroit; Wm. L. Harrigan, Mt. Pleasant; Dean W. Harris, Lansing; Henry H. Hartkop, Detroit; S. W. Hartwell, Muskegon; Frank W. Hedges, Detroit; Rose E. Herrold, Detroit; R. J. Himmelberger, Lansing; Harry Y. Hoffman, Detroit; A. J. Hollander, Detroit; James J. Horvath, Detroit; W. L. Howard, Battle Creek; Willard B. Howes, Detroit; F. A. Howland, Adrian; Verne G. Hunt, Detroit; Raymond Hussey, Detroit.

Wm. J. Jend, Detroit; R. C. Jeremias, Detroit; P. R. Johnson, Mt. Pleasant; W. H. M. Johnson, Detroit; C. G. Johnston, Detroit.

Zeno L. Kaminski, Detroit; J. B. Kass, Detroit; G. H. Kaven, Unionville; Cecelia S. Kay, Muskegon; H. J. Kehoe, Detroit; George T. Kelleher, Battle Creek; W. H. Kern, Garden City; Wm. B. Kerr, Saginaw; Saba Kessler, Bay City; David N. Kilmer, Reed City; Edward D. King, Detroit; C. Kirchgeorg, Frankenmuth; Ed. J. Koerber, Detroit; A. E. Kozlinski, Detroit; William T. Krebs, Detroit.

Ivan A. LaCore, Detroit; Paul E. Lance, Marlette; Robert M. Leitch, Union City; H. S. Leland, Detroit; R. E. Lemin, Detroit; Nicholas Lentini, Cheboygan; Arthur B. Levant, Detroit; Hartman A. Lichtwardt, Detroit; Louis S. Lipschutz, Eloise; Geo. M. Livingston, Detroit; Robert Lurie, Saginaw; Earl F. Lutz, Detroit.

R. M. McCaughan, Detroit; J. J. McClintock, Detroit; R. S. McClintock, Charlevoix; R. R. McCrumb, Lansing; John N. McNair, Detroit; Howard H. McNeill, Pontiac; H. A. Machin, Ann Arbor; John E. Maczewski, Hamtramck; Karl D. Malcolm, Ann Arbor; Jack N. Mandiberg, Detroit; John E. Manning, Saginaw; Clyde S. Martin, Port Huron; J. Harvey Maxwell, Detroit; Emil V. Mayer, Detroit; W. A. Maynard, Coleman; William H. Meade, Lansing; W. E. Mercer, East Lansing; Chas. C. Merkel, Grosse Pointe Farms; Lynford Miller, Adrian; Norman F. Miller, Ann Arbor; Martin K. Millikan, Dearoit; Nearl R. Moore, Bay City; L. J. Morgrette, Saginaw; J. A. Morley, Detroit; Nathan H. Moss, Detroit; Dirk Mouw, Grand Rapids; G. F. Muehlig, Ann Arbor; R. L. Mustard, Battle Creek.

E. S. Oldham, Breckenridge; F. P. O'Linn, Detroit; Paul V. O'Rourke, Detroit.

Hayden D. Palmer, Detroit; Camen R. Paynter, Detroit; M. M. Penslar, Detroit; Grace M. Perdue, Detroit; Frank L. Pierce, Detroit; M. H. Pike, Midland; R. A. Pinkham, Lansing; Harry Portnoy, Detroit; H. J. Prall, Lansing.

L. Paul Ralph, Grand Rapids; Henry K. Ransom, Ann Arbor; P. B. Rastello, Detroit; F. L. Rector, Ann Arbor; Jos. O. Revere, Mt. Clemens; Lawrence Reynolds, Detroit; C. J. Richards, Durand; Ned W. Richards, Saginaw; Gerald H. Rigterink, Kalamazoo; Maurice L. Richardson, Lansing; Richard G. Ries, Detroit; A. J. Roberts, Jackson; A. S. Rogoff, Detroit; Felix F. Rosenwach, Detroit; John Rottschafer, Alma; J. S. Rozan, Lansing; Milton J. Ruerer, Detroit; I. W. Ruskin, Detroit.

H. J. St. Amour, Detroit; A. G. Sack, Detroit; R. J. Sadowski, Detroit; A. R. Sanderson, Grosse Pointe; Kenneth R. Sandy, Flint; Sydney Scher, Mt. Clemens; Bruno W. Schmidt, Detroit; C. H. Schuler, Detroit; H. Allen Schwartz, Detroit; Joseph V. Scilla, Willow Run; Graham Sellers, Detroit; George A. Sherman, Lansing; E. R. Sherrin, Detroit; John L. Siefert, Detroit; C. E. Simpson, Detroit; John M. Sisson, Detroit; J. S. Sluyter, Grand Rapids; A. V. Smith, Mason; Clarence V. Smith, Detroit; E. Spurrier, Detroit; Hugh Stalker, Grosse Pointe; A. L. Stanley, Lansing; Saul C. Stein, Van Dyke; Albert S. Steinbach, Detroit; Jean Ellen Stevenson, Eloise; Dwight E. Stith, Detroit; C. J. Stringer, Lansing; Cullen E. Sugg, Grand Rapids; Donel Sullivan, Battle Creek; John E. Summers, Goodrich; M. V. Susskind, Jackson; Karl L. Swift, Detroit.

G. A. Tatelis, Detroit; Ivan B. Taylor, Detroit; Tom B. Thompson, Jackson; George A. Truester, Detroit.

C. J. Ujda, Wayne.

(Continued on Page 638)

"... the physiological state of the patient affects the mortality and morbidity of surgical practice as much or more than the correctness or skillfulness of that practice."[1] For that reason the fork must share with the scalpel the responsibility of favorable prognosis. The food the patient eats contributes greatly to the outcome of an operation. Faulty diet and a resultant avitaminosis make surgery more hazardous and impede recovery. For pre- or postoperative supplementation and therapy, Upjohn vitamins afford a full range of high-potency oral and parenteral formulas.

1: Surg., Gynec. and Obst 74:390 (Feb. 16) 1942.

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Say you saw it in the Journal of the Michigan State Medical Society

(Continued from Page 636)

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George L. Waldbott, Detroit; Albert A. J. Wallaert, Detroit; Kathryn Weburg, Petoskey; C. N. Weller, Detroit; Carl V. Weller, Ann Arbor; Alice Whitley, St. Clair Shores; D. Bruce Wiley, Utica; Kenneth P. Wolfe, Alma; G. H. Wood, Onaway.

S. A. Yannitelli, Northville; Jerome A. Yared, Detroit.

Victor M. Zerbi, Detroit.

Registration—March 14

Walter T. Anderson, Detroit; LeRoy L. Atler, Detroit; Ira Avrin, Detroit.

D. C. Beaver, Detroit; Max Blaine, Detroit; David S. Brachman, Detroit; Howard B. Burnside, Flint; J. Y. Burnstine, Detroit; Irving F. Burton, Detroit; Volney N. Butler, Detroit.

H. N. Calkins, Detroit; C. A. Campbell, Dearborn; H. Chesluk, Detroit; Harry L. Clark, Detroit; L. A. Comstock, Trenton; Richard C. Connelly, Detroit; Charles W. Cooley, Detroit; Evan L. Copeland, Decatur; S. O. Cotton, Detroit; E. R. Conrad, Detroit; Robert Cowen, Detroit.

Robert V. Daugharty, Cadillac; R. W. Dawson, Detroit; Carleton Dean, Lansing; Robert S. Drews, Detroit; S. F. Dunlap, Detroit.

W. A. Evans, Detroit.

Wm. R. Fitzsimmons, Detroit.

Samuel Gingold, Detroit; Geo. R. Granger, Detroit.

Ben Haddad, Detroit; Eugene A. Hand, Saginaw; T. N. Horan, Detroit; Wilfred A. Huegli, Detroit; L. W. Hull, Detroit.

Louis Jaffe, Detroit; Chas. J. Jentgen, Detroit.

William E. Keane, Detroit; Victor A. Kelmenson, Detroit; Hardy A. Kemp, Detroit; Chas. W. Knaggs, Detroit; F. S. Kucmierz, Detroit; John A. Kirk, Detroit.

Alfred C. LaBine, Detroit; John S. Lambie, Pontiac; Karl K. Latteier, Detroit; C. B. Loranger, Detroit; R. P. Lytle, Detroit.

W. G. McDonald, Detroit; J. A. McGarvah, Detroit; J. A. McLandress, Saginaw; Kenneth E. Mapletoft, Detroit; Willard D. Mayer, Detroit; Henry J. Meyer, Saginaw; Spencer W. Miller, Alma; G. B. Myers, Detroit.

E. J. Nalepa, Detroit; Reed M. Nesbit, Ann Arbor; Arthur K. Northrop, Jr., Detroit; C. S. Norton, Detroit.

G. M. O'Brien, Detroit; D. J. Ottilie, Detroit.

E. S. Parmenter, Alpena; I. S. Pfeffer, Detroit; Hazen Price, Detroit.

Raymond J. Reichling, Grosse Pointe; H. H. Riecker, Ann Arbor; George A. Roberts, Detroit; Harold A. Robinson, Detroit; Jack Rom, Detroit; Saul Rosenzweig, Detroit.

Lloyd L. Savage, Caro; Raymond J. Screen; Wyandotte; Richard Sears, Muskegon; Oscar D. Schwartz, Detroit; Leland D. Schaeffer, Detroit; H. I. Sparling, Northville; C. H. Stevens, Detroit; M. P. Stonestreet, Detroit; Walter A. Stryker, Detroit.

Aaron Taylor, Detroit; Theo. Togstad, Detroit; Merald G. Turner, Goodrich.

Richard J. Valone, Detroit; H. E. Vergosen, Detroit.

J. Paul Walker, Detroit; Roger V. Walker, Detroit; Irving A. Warren, Detroit; Lynn F. Webber, Detroit; Charles J. Westover, Plymouth; Colonel A. E. White, Battle Creek; Henry Wiechowski, Hamtramck; C. G. Williams, Detroit.

MEMBERSHIP AND FELLOWSHIP DEFINED

Every Member in good standing in the constituent medical association of the state in which he is engaged in practice whose name is officially reported to the Secretary of the American Medical Association for enrolment becomes automatically a Member of the American Medical Association and is not called on, as such, to pay any dues or to contribute financially to the Association.

Members of the American Medical Association who graduated at recognized medical schools are eligible to apply for Fellowship.

To qualify as a Fellow, a Member in good standing is required to make formal application for Fellowship, to pay Fellowship dues and to subscribe for the *Journal* (AMA). Applications must be approved by the Judicial Council. Fellowship dues and subscription to *The Journal* are both included in the one annual payment of $8.00, which is the cost of *The Journal* to subscribers who are not Fellows.

Only those Members who qualify as Fellows are eligible for election as officers, may serve as members of the House of Delegates, may register at the annual sessions of the Association or may participate in the work of its scientific sections.

Members of constituent state medical associations pay dues to those bodies, but as Members they pay nothing to the American Medical Association. Fellows pay dues and subscription to *The Journal* in the sum of $8.00 a year, which has nothing to do with county or state dues.

According to an amendment to the By-Laws of the American Medical Association, no physician may be officially recorded as a Member of the American Medical Association except on the basis of membership in *one* constituent state medical association and that one the association of the state in which the physician concerned maintains legal residence and engages in the practice of medicine.

DOCTORS EXPECT ANOTHER BIG POLIO EPIDEMIC

Another big polio year is expected this summer by infantile palaysis experts. Without making any specific predictions, they told members of the American College of Physicians that there will probably be a lot of polio in the United States and elsewhere for a number of years to come.

One authority, Dr. Thomas Rivers of the Rockefeller Institute was quoted as having said that he feels we are in a pandemic. Pandemic is the term scientists use to describe a world-wide epidemic, such as the influenza outbreak of 1917-1918.

During the last four years there has been the largest total number of cases of polio in the United States in the history of the nation, Dr. Edward A. Piszczek of Chicago reported.

The increase is not just a matter of more accurate reporting. Doctors actually are seeing more cases, Dr. Piszczek said. The virus germ that causes infantile paralysis has grown more virulent. Until it begins to lose some of its virulence, we shall go on having lots of polio cases every year, the authorities believe. Since the beginning of this year 33 states have reported more polio than for the same time last year. Authorities are watching with special concern increases in some states which for the past four or five years have had very little polio.

—*Science News Letter,* May 17, 1947.

The JOURNAL

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VOLUME 46 JUNE, 1947 NUMBER 6

Anesthesia in General Practice

By J. DePree, M.D.

Grand Rapids, Michigan

Anesthesia has made great strides forward in the past years. All the newer anesthetic drugs, new methods of administration, the latest adjuncts to good anesthesia are necessarily confined to hospital practice. The impracticability of carrying excess equipment limits the general practitioner to the use of ether, chloroform, and local anesthetics.

Ether has been and still is the safest anesthetic drug. An ether anesthetic, properly given, is satisfactory for most surgical procedures. The induction should be slow and easy in order to obviate choking and coughing. A patient should be carried as light as possible but as deep as necessary. Anoxia is an ever-present danger with ether as well as with other anesthetics. One should guard against it by giving the patient air as well as ether vapor, even by taking the mask off once in a while, especially if the surgeon thinks that the patient is straining. The trouble may be deep, forced respirations caused by accumulation of carbon dioxide from an insufficient or obstructed airway, tight mask, or a mask with too many wet towels around it. Given carefully, ether should not cause too much postoperative vomiting.

Ether should not be given in cases complicated by acidosis, acute respiratory infection, suppurative pulmonary tuberculosis, or in the presence of increased intracranial pressure. Ether vapor in combination with air or oxygen is explosive. Ether should not be used when there is an actual cautery or open flame anywhere near.

Chloroform is a dangerous drug but it has one advantage over other volatile anesthetic agents. It is not inflammable and can be given in homes heated by the old base burner and illuminated with a kerosene lamp.

Induction with chloroform is pleasant and rapid. However, it is not advisable to use chloroform except when no other agent can be used, and then it must be given cautiously. Some men use chloroform as a general anesthetic and give a good anesthesia. Its routine use, however, is not to be encouraged as it is prone to cause liver damage. Death under chloroform anesthesia is due to cardiac failure, not respiratory failure.

Ethyl chloride is used quite frequently for short minor operations and for induction to an ether anesthetic. Its action is similar to chloroform but less intense. It is explosive when mixed with air.

Divinyl oxide (vinethene) has received quite some attention in recent years. It is a good agent for short operations of one-half hour or less, or for inductions. It produces a rapid induction but stimulates the salivary glands and the glands of the pharynx and respiratory tract. The result is an excessive amount of mucus. Relaxation of the abdominal wall is not satisfactory.

All the equipment necessary to administer the above agents is a mask and an airway. Today every community of any standing has a hospital. The latest developments in anesthesia should be performed only in a hospital because there will be found the necessary equipment, equipment too

Presented at the first annual Michigan Postgraduate Clinical Institute, Detroit, March 13, 1947.

cumbersome to carry in a car, equipment essential to good anesthesia, as a patient may have to be resuscitated or maintained by controlled respiration. Resuscitation may be performed by the prone methods but these produce only about 25 per cent of an adequate respiratory exchange. Intermittent positive pressure on a rebreathing bag increases this exchange to about 75 per cent. Equipment, however, will do little good unless one or two of the practitioners of the community realize the opportunities in anesthesia. Time spent to attend a course and to become proficient in the uses of gas machine would be a worthy investment—an investment in the safeguarding of lives as well as in economy.

Pentothal sodium is one of the new anesthetic agents. It was introduced by Lundy in 1934, and it did not take long to become popular with patients and surgeons. This drug has done more to remove the fear of surgery from the minds of patients than anything else since the development of anesthesia. Pentothal sodium is a barbiturate of the ultra-short-acting type. It is rapid in action and is broken down and eliminated rapidly. Alone, this agent is used only in short operations. In longer operations it may be given in conjunction with a gas anesthetic, such as nitrous oxide or cyclopropane. Induction is extremely rapid but relaxation is not too good. It is a respiratory depressant. This, and the poor relaxation, is why it is essential to use a combination of pentothal and another anesthetic agent. When another agent is used with pentothal, the oxygen percentage of the gas mixture can be kept high.

Pentothal sodium must not be given in circulatory disturbances and severe anemias, kidney or liver diseases, toxemias and acidosis, to the elderly or to infants, in chronic pulmonary disease with low vital capacity, or in respiratory obstructions, acute or chronic. It should not be given in operations where the patient's airway may be obstructed.

The drug does not abolish the pharyngeal or laryngeal reflexes until late in anesthesia and the patient may develop severe paroxysams of coughing or laryngospasm at any time.

Premedication with atropine or hyoscine is essential with pentothal sodium in order to obviate coughing or laryngospasm. These complications may be relieved by 1/75 grain of atropine, or by using curare or intravenous procaine. The anesthetist must be ready to resuscitate the patient or to pass an intratracheal catheter. Pentothal sodium should never be given at any place where these contingencies cannot be instantly combated.

Curare has been universally adopted by anesthetists in recent years to produce muscular relaxation. One preparation used is Intocostrin by Squibb. Cullen reported a large series of cases in 1944. Curare allows the use of a lighter plane of anesthesia with satisfactory relaxation. Cullen recommended that the anesthesia be leveled off at the second plane of the third stage and intocostrin given intravenously when the skin incision is made. If necessary this initial dose can be added to with a smaller dose if relaxation is not sufficient, and smaller subsequent doses if needed. The action starts in three to five minutes and lasts about forty-five minutes. The effect produced is a paralysis of the muscles, first of the head and neck, second of the extremities and trunk, and third of the diaphragm. A cessation of respiration because of the paralysis of the diaphragm does not occur except in overdosage, and is transient. It is treated by intermittent positive pressure of the rebreathing bag. Prostigmine is reputedly the antidote.

There are two positive contraindications to the use of curare. First the inability of the anesthetist to perform artificial positive-pressure resuscitation and second the presence of myasthenia gravis.

Curare should not be used in ether anesthesia, or if used should be given in much smaller doses than with other anesthetic agents. Ether, itself, has a curariform action.

Finally, curare is not a substitute for a good anesthetic but is a valuable adjunct to use for producing maximum relaxation. When using curare, it is essential that the patient be premedicated with morphine and scopolamine.

The intravenous use of procaine is another adjunct which is being used in anesthesia with remarkable success. The unpremedicated, conscious patient manifests toxic reactions when even a small amount of procaine is rapidly injected into the circulation. The reactions are circulatory collapse, cerebral irritability and convulsions, and respiratory failure. Pentothal sodium controls the convulsions. Manual compression of the rebreathing bag corrects the anoxia resulting from the respiratory failure.

Lundy, in 1940, showed that intravenous procaine could be safely used. It must be given slowly and in very dilute solution. The signs of an overdose are pallor, rapid heart rate, twitching of the muscles of the face, and unconsciousness. If these

signs appear, the procaine must be discontinued immediately and pentothal sodium given intravenously to prevent further reactions.

That is the effect in the conscious patient. The anesthetized, unconscious patient, however, tolerates the intravenous use of procaine in relatively high concentrations. Here the patient has protection against the toxic effect.

Procaine protects the myocardium from acute arrhythmias, prevents laryngospasm, depresses visceral abdominopelvic reflexes, relaxes smooth muscle of the tracheobronchial tree and prevents bronchiolar spasm. Furthermore, with the use of intravenous procaine the anesthesia need not be so deep. It has no effect on arrhythmias existing before anesthesia.

At Blodgett Memorial Hospital, Dr. Frank Thompson and myself have used it in coughing and laryngospasm, with pentothal anesthesia; and in hiccoughing under anesthesia. It was used in a case of laryngoscopy accompanied by removal of sutures from the posterior pharynx. Esophagoscopy for removal of a bone was done with remarkable ease under pentothal anesthesia with intravenous procaine. It was used for the manual removal of a retained placenta.

Procaine, given intravenously, can be safely and advantageously used as an adjunct to anesthesia. Its action is rapid and short, since procaine is broken down in about fifteen minutes. The limitations and optimum dosage of intravenous procaine have not yet been determined. It must not be given by anyone who is not able to resuscitate the patient and to maintain controlled respiration.

Spinal anesthesia has become very widely used in recent years. Properly given, it is a safe anesthetic. Spinal anesthesia has been and is being given by men not trained in this procedure. This is not safe.

This form of anesthesia should be given only by men trained in its use. A complete knowledge of several subjects is necessary: the anatomy and functions of the central, sympathetic and parasympathetic nervous systems; the physiology and mechanics of the respiratory and the circulatory systems; the pharmacology and action of the different spinal anesthetic drugs; and the pharmacology and action of the various vasopressor and stimulant drugs. Here, too, the anesthetist must be able to resuscitate the patient.

A patient under spinal anesthesia must be carefully watched by someone who knows the complications which may develop and who knows how to treat them. The blood pressure may drop to dangerous levels; the heart rate may accelerate greatly; the respirations may become depressed and may cease completely. Carbon dioxide can accumulate in excessive amounts or the patient may suffer from lack of oxygen.

The most commonly used spinal anesthetic drugs are novocaine, pontocaine, and nupercaine. These vary greatly in toxicity and length of action. Novocaine is the least toxic drug of the three.

Some anesthetists use glucose in the solution in order to make it definitely heavier than spinal fluid. This is an advantage in certain operations. Ephedrine can be added in definite proportions in order to increase the duration of action.

Spinal anesthetic drugs are administered by either the single injection, or by the continuous, intermittent or fractional injection techniques. This continuous technique was devised by Lemmon so that novocaine could be used in long cases. Later, Tuohy improved on Lemmon's technique by making the injection through a ureteral catheter which had been introduced into the spinal canal through a special needle. By this latter technique the ordinary pad can be left on the operating table and the patient can be more freely moved without dislodging the means of injection.

Summary

It has been shown that there is no new anesthetic agent which can replace the agents in use for emergency home and office use. Familiarity with them should not breed contempt.

The action and use of pentothal sodium as an anesthetic, and of curare and intravenous procaine as adjuncts to a good anesthetic have been briefly described and their advantages and contraindications listed in part.

It has been shown why every hospital should have on its staff a physician who is capable of giving anesthesia.

It has been shown how essential it is that the anesthetist be able to resuscitate a patient and to maintain controlled respiration by intermittent positive pressure of the rebreathing bag.

The choice of an anesthetic depends upon many factors. Chief among these is the ability of the anesthetist. Unless he is trained in the use of all anesthetic agents and procedures, the choice of the anesthetic is limited to the one agent and the one technique with which he is familiar.

Treatment of Urinary Tract Infections

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In a discussion of the treatment of urinary tract infections, one first must give consideration to the methods and findings by which the diagnosis may be made. The urine must be collected in a manner that will eliminate the possibility of contamination, which applies particularly to the female. The voided specimen of urine in the female is usually contaminated grossly by vaginal secretions. Accordingly it is imperative to catheterize the female in order to attach any significance to the urinalysis. In the male, it is necessary to retract the prepuce, if one is present, cleanse the glans with an antiseptic solution, and collect a second-glass specimen of urine. In urine collected in such a fashion, pyuria signifies urinary tract infection. Amicrobic pyuria most frequently indicates a tuberculous urinary tract infection, but occasionally represents a virus infection. The sediment of the centrifuged urine should be stained either with methylene blue, or a Gram stain for the gross identification of bacteria. It is not entirely necessary to culture the organisms present in the urine at the initial examination prior to the administration of a therapeutic measure. The recognition of bacilli or cocci or both in the stained sediment is sufficient to outline the primary course of therapy. However, when after a suitable trial the urinary tract infection fails to respond to the usual therapy, further detailed urologic investigation, including culture of the urine for ultimate identification of the offending organism, is mandatory. For the most part, when bacteria are present in a properly collected sample of urine, it may be assumed that the upper urinary tract, i.e., kidneys, is involved by the infection. Only occasionally will the infection be primary in the lower urinary tract, i.e., bladder, prostate, seminal vesicles or urethra. Often infection in these latter sites merely reflects unsuspected infection in the kidneys. Accordingly, with these basic principles in mind, if the treatment to be outlined below fails of its purpose, one must perform a complete examination of the urinary tract to determine the possible presence of complicating pathologic conditions which would serve to perpetuate the infection, i.e., calculus, neoplasm, obstruction, foreign body, or long standing infection which had produced cicatrization of some portion of the urinary tract. Such an examination entails cystoscopy, with catheterization of the ureters to obtain fractional urine samples from each kidney for routine analysis, pyogenic culture, and guinea pig inoculation; renal function studies are also carried out and retrograde pyelograms are made. Even in the situation where the routine therapy successfully eradicates the urinary tract infection, one usually should study the upper urinary tract by means of excretory pyelography, since the newer chemotherapeutic and antibiotic agents may achieve sterilization of the urine even in the presence of obstruction, and the omission of such an investigation might prevent the discovery of a lesion at a time when its detection might lead to reparative surgery.

Criterion for cure following treatment of a urinary tract infection should consist of at least two negative urinalyses with absence of bacteria on stained examination of the sediment. Many urologists believe that this indication of sterility is probably more reliable than the information afforded by culture, since it tends to eliminate the factor of accidental contamination. It should be emphasized that a patient who has been successfully treated for a urinary tract infection should not be discharged from observation for at least six to eight weeks after the last negative urinalysis, for recrudescence of the infection can occur without symptoms and, if not discovered and adequately treated, can go on to chronicity.

With the addition of numerous drugs to the armamentarium available for therapy in urinary tract infections, the physician is occasionally hard put to decide upon the particular agent to employ in an individual instance. A brief discussion of the most important urinary antiseptics and the situations in which they may be utilized to best advantage would appear to be in order.

1. Perhaps the most venerable urinary antiseptic is hexamethyleneamine, otherwise known as

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methenamine, or commercially as "urotropin." Its effectiveness depends upon the splitting off of formaldehyde in the presence of an acid medium. It is ineffective in an alkaline medium, since it is not an antiseptic in its own right. It has been shown by Helmholz[5] to be efficient only when the urine is maintained at a pH as close to five as possible. This degree of acidity often does not obtain until some acidifier such as ammonium chloride is used. The reaction of the urine may be simply determined by the use of nitrazine paper, and proper acidity should be achieved before instituting therapy with methenamine. This drug is effective in controlling Gram-negative bacillary infections. It carries the disadvantage of inducing bladder irritation in some patients by action of the formaldehyde upon the mucosa of the urinary tract. It is administered in doses of 4 to 5 gm. daily with 5 to 8 gm. daily of ammonium chloride. The latter drug may be increased as necessary to obtain the desired acidity of the urine. The antiseptic should be given for ten to fourteen days, if tolerated by the patient. Time has proven the ineffectiveness of this urinary antiseptic in the majority of infections, but this should not blind the clinician to the fact that methenamine has always been curative in some cases and that it may be found the only agent, when all others have failed, that will bring about a sterilization of the urine.

2. Following the discovery that ketogenic diets with the accompanying acidosis were effective in the treatment of chronic bacillary urinary infections, the use of mandelic acid was proposed by Rosenheim. It was found to be effective against Gram-negative bacilli, except proteus ammoniae, and streptococcus faecalis. It too was found to be effective only in urine of pH less than 5.5, and in a concentration of 0.5 per cent or greater. Both methenamine and mandelic acid share the disadvantage of being effective only in concentrations that are made possible when the urinary output is sharply curtailed, which violates one of the principles of treatment of urinary tract infection, i.e., large urinary output. The occasional difficulty encountered in maintaining the optimal urine acidity provides another disadvantage in their use. Mandelic acid often induces nausea and vomiting, and after prolonged administration may produce hematuria, with casts in the urine.

A satisfactory mode of administration is syrup of ammonium mandelate, 15 c.c. four or five times daily, each 15 c.c. of the syrup containing 3 gm. of mandelic acid. Should the urine require an additional acidifying agent, ammonium chloride 5 to 8 gm. daily may be given simultaneously. It is advisable to maintain the drug dosage for about fourteen days.

3. The sulfonamides as a group have provided powerful agents for urinary antisepsis. In general, they work advantageously against Gram-negative bacilli. Sulfanilamide is most effective against Gram-negative bacilli alone, while sulfathiazole, in addition, is effective against staphylococci and partially against streptococci; and when the urine is acid, sulfathiazole has a moderate effectiveness against streptococcus faecalis. Sulfadiazine may be placed in about the same range of effectiveness as sulfathiazole. However, the factors of solubility in the urine, toxicity, and variations in antibacterial activity must be considered. Sulfacetimide (commercially sold as "sulamyd") has the advantage of high solubility even in the physiological acid range of the urine, thereby minimizing almost to a negligible point the danger of concrement formation. In addition, it combines the features of good antibacterial activity, low toxicity, and rapid renal elimination resulting in high urinary level. *In vitro* experiments with bacteria isolated from infections of the urinary tract, performed by Lehr,[6] indicate that whereas in very low concentrations (1 to 5 mg. per cent) sulfathiazole possesses the highest bacteriostatic activity, sulfadiazine and sulfacetimide approach its effectiveness in concentrations usually maintained in the urine of a patient under treatment (50 to 200 mg. per cent). Sulfanilamide appears to have the lowest antibacterial effect. However, the marked tendency of sulfadiazine and sulfathiazole to form urinary concretions suggests the preference for sulfacetimide. It is usually administered in dosages of 3 to 4 gm. daily for the first two to three days of the acute urinary infection, followed by daily dosages of 2 gm. (0.5 gm. q.i.d.) for an additional five to six days. Alkalinization of the urine does not appear to be necessary when this drug is administered.

4. Although the majority of urinary tract infections trace their etiology to the colon bacillus, the minority group due to pyogenic cocci assumes an important role. This group has particular significance, since some members exhibit urea-splitting properties, resulting in an alkaline urine, which contribute to the formation of phosphatic calculi. The introduction of penicillin, with its potency in

combatting coccal infections, immediately led to its use in this group of infections and it has found its chief usefulness in the treatment of staphylococcus aureus, beta hemolytic streptococcus, and staphylococcus albus infections. It has almost no place in the treatment of infections caused by streptococcus faecalis, and fails utterly in those produced by B. coli and B. pyocyaneus. In treating infections caused by mixed organisms, comprising both cocci and bacilli, the penicillin will often fail *in vivo* to eliminate the cocci, despite *in vitro* sensitivity of the organism to clinical doses of penicillin. This paradox has been explained by the discovery of Abraham and Chain[1] that some Gram-negative rods, including B. coli, elaborate a pencillinase which destroys the inhibitory effects of penicillin. In such cases it is necessary to eradicate the penicillinase-producing bacilli before the cocci can be treated successfully with penicillin. Recently it has been suggested that a combination of penicillin and streptomycin might act concurrently, for the streptomycin would eliminate the penicillinase-producing organisms, thereby allowing the penicillin to act unrestrained against the cocci.

In those urinary infections that are due to mixed organisms, we usually employ both penicillin and "sulamyd" during the first course of therapy, the penicillin being administered in doses of 40,000 units intramuscularly every three hours, day and night. Both drugs are continued for seven to nine days. If effective, they rarely are needed for longer periods of time.

In discussing the treatment of urinary tract infection with penicillin, one must not omit the consideration of acute gonococcal urethritis. Although the sulfonamides such as sulfathiazole and sulfadiazine are effective in the management of this disease, penicillin far surpasses them in its efficacy. Various patterns of therapy have been advised. Early in the use of penicillin, it was found that 20,000 units administered intramuscularly every three hours for five doses would result in a 95 per cent cure. This outline of treatment entailed the disadvantage of multiple injections with its consequent interference with the patient's and physician's daily routine. More recently the eminently satisfactory treatment described by Romansky[8] and corroborated by Leifer[7] and Chinn[3] has found favor. This consists of a single intramuscular injection of 300,000 units of calcium penicillin in a 4.8 per cent mixture of beeswax and peanut oil. This achieves a cure rate of 93 to 95 per cent, with almost 100 per cent cure following a second similar injection in the group of 5 to 7 per cent failures. An alternate method of treatment was suggested by Heller,[4] consisting of a three-hour schedule of intramuscular injections of sodium penicillin: 40,000 units at zero hour, 40,000 units at the end of the first hour, 40,000 units at the end of the second hour, and 80,000 units at the end of the third hour. This regime achieves a 96 per cent cure rate. In utilizing this treatment, one may mask the coincidental existence of a syphilitic infection, and a serological test for syphilis should be made three months after the treatment of the gonorrhea has been accomplished.

5. The most recent antibiotic to be found bactericidal against organisms invading the urinary tract is streptomycin. It has been shown to be effective *in vitro* against various Gram-negative bacilli frequently responsible for urinary infections which prove refractory to sulfonamides and penicillin. Whereas the arbitrary initial use of penicillin without determination of the sensitivity of the offending organism to its action may be pardoned by virtue of its present accessibility and reasonable cost, this same practice cannot be condoned in the use of streptomycin. Its present high cost and scarcity preclude its promiscuous administration; furthermore not all organisms are affected by streptomycin. It is important, therefore, to use this agent only in the treatment of infections that are known to be due to streptomycin-sensitive organisms. Most of the larger medical centers have laboratory facilities for determining streptomycin sensitivity on urine cultures, but this service has not been generally available to the majority of physicians. The awareness of this problem has led Dr. G. D. Cummings and his co-workers at the State Laboratory in Lansing to include the determination in the complete group of procedures performed by this co-operative and reliable organization. It now furnishes a service to members of the medical profession in the State of Michigan involving the performance of cultures of urine for pyogenic organisms, with determination of the sensitivity of the cultured organisms to streptomycin, at no cost to the patient or physician. Certainly when one encounters an infection that fails to respond to the usual measures, and organic pathologic disease other than the presence of infection has been ruled out, the attending physi-

cian should utilize this service prior to the administration of the drug.

The results of streptomycin therapy are most impressive in infections caused by B. coli, Aerobacter aerogenes, Proteus amoniae and vulgaris. Pseudomonas aeruginosa and certain strains of streptococcus faecalis respond only moderately satisfactorily (Adcock[2]). Using 2 to 3 gm. daily of streptomycin, a blood level of 20 units per c.c. serum can be attained, and those organisms falling within this range of sensitivity, as determined by *in vitro* studies, may be considered as susceptible to streptomycin therapy. It has been found that the effectiveness of streptomycin is enhanced when the urine is strongly alkaline—around pH of 7.2-7.4. This generally can be attained by the oral administration of sodium citrate. This can be administered conveniently by mouth, one teaspoonful of a 25 per cent aqueous solution of the drug, five times each day. The urine should be tested daily with nitrazine paper to assure the success of this endeavor. The dosage of the sodium citrate may be increased if need be, or diminished should the urine be sufficiently alkaline. Potassium citrate may be substituted for the sodium salt when the cardiac status of the patient poses a problem. Five times a day, 400 mg. of streptomycin are administered intramuscularly, in association with the sodium citrate. The schedule of dosage is on the basis of six doses daily, omitting the 2 A.M. dose. It is preferable to hit the organism hard initially in order to avoid the development of resistance to the drug by the organism, as has been observed on occasions. Treatment is continued a maximum of ten days, and may be stopped at any time that the cultures of the urine show no growth. When streptomycin is effective the bacteria generally disappear from the urine in three to seven days. The neurotoxic effect of streptomycin deserves mention at this point. Involvement of the eighth nerve may result in transient deafness or disturbances in the vestibular apparatus associated with marked vertigo. These toxic manifestations rarely occur during a ten-day course of treatment.

6. Some cases of amicrobic pyuria, proved not to be tuberculous in origin, may respond satisfactorily to two or three intravenous injections of neoarsphenamine 0.3 to 0.6 gm. administered with the usual precautions. This same treatment may prove successful occasionally in resistant coccal infections.

Summary

1. In acute urinary infections caused by bacilli, administer Sulamyd 4 gm. daily for two to three days, followed by 2 gm. daily for seven days. When cocci are also present, penicillin 40,000 units every three hours intramuscularly is administered simultaneously. While this treatment is in progress, excretory urograms should be made to rule out gross pathologic changes in the upper urinary tract, unless the infection is obviously one of the genital or lower urinary tract. At the end of a week, if the infection has failed to respond, the therapy is continued for another seven days. If at the end of the initial period of therapy, the urine appears negative, a repeat urinalysis is performed after four to five days without therapy. Should infection recur at the end of this time, another seven days of similar treatment is resumed.

2. When the infection remains refractory after fourteen to fifteen days of treatment, a complete urological investigation is performed according to the principles previously discussed and in the manner described above, for the eradication of resistant infections will often depend upon diagnosis and correction of gross urinary tract disease such as calculus, hydronephrosis or other obstructions, and many refractory infections owe their chronicity to the presence of unsuspected tuberculosis.

3. In cases refractory to the initial treatment, the organisms then should be studied from the standpoint of their response to streptomycin, and if this treatment appears to hold promise, it should be employed.

4. In the event of failure of streptomycin, other measures should be attempted, i.e., employing different members of the sulfonamide group, or using methenamine and/or mandelic acid. Unfortunately, even with the apparently powerful array of urinary antiseptics now available, a certain small percentage of cases will prove to be resistant to all forms of therapy. This group awaits the discovery of still other therapeutic agents.

References

1. Abraham, E. P., and Chain, E.: Nature, London, 146:837, (Dec. 28) 1940.
2. Adcock, J. et al: In press.
3. Chinn, B. D. et al: M. Ann. District. of Columbia, 15:62, (Feb.) 1946.
4. Heller, J. R.: J.A.M.A., 131:1480-1482. (Aug. 31) 1946.
5. Helmholz, H.: J. Pediat., 1:73-81, (July) 1932.
6. Lehr, D.: J. Urol., 54:87-105, (July) 1945.
7. Leifer, W. et al: New England J. Med., 233:583, (Nov. 15) 1945.
8. Romansky, M. J. et al: J.A.M.A., 128:404-407, (June 9) 1945.

Minimal Tuberculosis

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THE VAST INCREASE in x-ray service in this country is reflected in the fact that almost two years after the termination of the war with Germany, x-ray film is still being allocated to the hospitals in this country on a quota basis. This increase in x-ray service can be attributed to a number of reasons, namely, the screening of our servicemen and women on entering and again on separation from service, the widespread adoption of hospital insurance, excellent economic conditions generally throughout the country, the introduction of photoroentgenology, the x-raying of all admissions to general hospitals, and again the fact that the public as well as the profession has become aware of the value of this service. A greater percentage of this increase in x-ray service has been in chest x-ray, and this fact in turn has made medical men aware of the prevalence and the importance of minimal tuberculosis.

It is equally important that physicians familiarize themselves with the proper clinical management of these patients. It must be recognized that not all parenchymal lesions are tuberculous, nor, on the other hand, are all tuberculous lesions active. During the past year the Michigan Department of Health by means of mobile units x-rayed approximately 170,000 patients. Of this group, 2,518 patients were shown to have parenchymal densities suggesting reinfection tuberculosis, a percentage of 1.48 of the x-rayed group. It stands to reason that only a small percentage of these patients have lesions demanding hospitalization. It is equally important, however, to recognize that every one of these patients with abnormal parenchymal lesions should be thoroughly processed clinically to determine the exact status of the lesion. The clinical follow-up of these patients is not particularly difficult but it does require that the physicians should be meticulous in carrying out certain details. If the physician summarily dismisses the patient's problems by the mere fact that he has no symptoms and possibly one or two negative smears, then sooner or later both he and his patient will find themselves in trouble.

TABLE I. COMPARATIVE STUDY OF POOLED SPUTA AND GASTRIC WASHINGS

	Totals	
	7-day Sputa	Gastric Aspiration
Number of patients	133	133
Number of specimens	171	171
Average per patient	1.3	1.3
Negative by all methods	136	84
Positive slide examination	3	14
Positive by pig and/or culture	35	87
Per cent positive by pig and/or culture	20.46	50.80

In the clinical processing of these patients with evidence of parenchymal lesions in their x-ray, I would suggest the procedure as outlined below:

History:

Exposure: Has patient had a recent exposure? Has patient had a heavy exposure? Is the contact in the patient's immediate family?

Past History:

Past Illnesses; One should pay particular attention to those illnesses suggesting the tubercle bacilli as an etiological factor, usually pleural effusion, spontaneous pneumothorax, suppurating glands, et cetera.

Present Complaint:

Does he present: Unusual fatigue?
Weight loss?
Susceptibility to colds?
Blood spitting, et cetera?

It must be emphasized that patients with minimal lesions frequently have no symptoms.

Physical Examination:

Physical findings as regards the chest may be entirely negative.

Occasionally râles may be present over site of lesions.

Physical examination should be complete to determine presence of any coexisting lesions.

X-Ray Interpretations:

Much can be learned from the film by those experienced in their reading. It is not always a safe procedure to make a positive diagnosis of tuberculosis from a single film without corroborating evidence. All parenchymal lesions are not tuberculous; all tuberculous parenchymal lesions are not active. X-ray densities suggest degree of activity but this may be tricky in minimal lesions.

Laboratory Screening:

Sputum examination: This can be the deepest pitfall in the clinical process. The clinical experience of many of us was weaned in college dispensaries on far advanced tuberculous patients who could raise tubercle bacilli with every gulp. That picture must be erased from the mind in dealing

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with minimal cases. There may be no sputum and, if so, it can be repeatedly negative by direct smear. I recommend that patients submit four or five single specimens, and if they are negative by smear, one should immediately obtain a gastric aspiration from a fasting stomach to be processed preferably both by culture and guinea pig inoculation.

TABLE II. COMPARATIVE STUDY OF POOLED SPUTA AND GASTRIC WASHINGS IN RELATION TO PULMONARY INVOLVEMENT

	Minimal		Moderately Advanced		Far Advanced		Pleural Effusion	
	7-day Sputa	Gastric Aspiration	7-day Sputa	Gastric Aspiration	7-day Sputa	Gastric Aspiration	7-day Sputa	Gastric Aspiration
Number of patients	50	50	24	24	49	49	10	10
Number of specimens	76	76	28	28	56	56	11	11
Positive slide examinations	0	6	0	1	3	7	0	0
Positive by pig and/or culture	10	46	7	19	16	19	2	3
Per cent positive by pig and/or culture	13	60	25	67	28	34	18	27

Some physicians may raise the question of pooled sputa as an intermediary procedure. Several years ago we made a study of the comparative value of the pooled sputa as compared to gastric aspirations for determining the presence of acid-fast bacilli. Our study proved to our satisfaction that the gastric aspiration produces positive acid-fast organisms at a much greater percentage than pooled sputum specimens (Table I). We have subsequently abandoned pooled sputa as a routine measure in our institution. It was particularly interesting to note in our study that the greater discrepancy occurred in the presence of minimal lesions, where the ratio of positive acid-fast organisms by gastric aspiration was approximately 4 to 1 over that by pooled sputa (Table II).

It is equally important to recognize that gastric contents must be submitted to the laboratory for processing promptly. Gastric contents under ordinary mailing conditions are practically worthless if seventy-two hours have elapsed prior to the time that the specimen is neutralized. The effect of this time interval in the specimen is shown in Table III. We also feel that pooled gastric aspirations are only as good as the last specimen introduced to the pool.

In repeating gastric aspirations on patients who are negative, we must be guided by the medical indications and follow-up x-rays on the patient. If the x-ray does not appear too stable, then the gastric aspiration should be repeated at least twice in the following six-month interval. Patients with positive gastric aspirations should be recognized as having an ulcerating lesion. It may be of low-grade but it is still throwing off bacilli. It would be best if all these patients could be hospitalized for their disease.

TABLE III. RESULTS WITH THIRTY-THREE GASTRIC SPECIMENS NEUTRALIZED AFTER VARYING PERIODS

	Total	Positive Pig and/or Culture	
		Number	Per cent
Immediate treatment	33	24	73
24-hour treatment	33	15	45
48-hour treatment	33	7	21

A Mantoux test should always be done as a matter of routine, with either Purified Protein Derivative or Old Tuberculin for intracutaneous use. Patch tests have no place in the differential diagnosis.

It is important that these patients, regardless of negative gastric aspirations, maintain clinical contact. The time and the extent of this contact must depend to a great extent on the patient and the prevailing evidence.

MSMS

CULTURE DIAGNOSIS OF TUBERCULOSIS

Inoculated tubes are sealed carefully with paraffin and incubated for six weeks at 37°. All the tubes are inspected once a week, the first time two weeks after inoculation.

If the cultures show no macroscopic growth after six weeks, the result of the cultivation is regarded as negative without any further examination. No microscopic examination is made of smears from such cultures.

The Application of Psychiatry to the General Practice of Medicine

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MAY I BEGIN with a bedside incident in the life of our beloved Osler. "Mother," said Osler, "I would like you to tell Dr. Walsh something about your past life." "When were you first in a hospital?" "At twenty-seven." "What was the matter?" "I had sarcoma of the right knee." "What did they do for it?" "They cut off the right leg at the hip." "Did you get entirely well?" "Yes, entirely well." "When were you in again?" "At forty-two." "What was the matter?" "I had cancer of the left breast." "What did they do for it?" "They cut off the left breast and left arm." "Did you get entirely well?" "Yes, entirely well." "What are you in the hospital for now?" "For rheumatism; and Doctor," she said, with tears in her voice, and catching his hand, "I hope you will make me well in a hurry, because I have to go home to take care of my grandchildren."*

Contrast this strong-minded seventy-five-year-old woman with the weaker-minded twelve-year-old little girl brought to the hospital on a stretcher with a questionable diagnosis of heart disease. Her only complaints were palpitation, dyspnea, anxiety, and extreme weakness. In a few weeks her confidence was gained enough so that she was able to reveal that her first "heart attack" occurred in school. In a short while she recalled she had been studying history, and remembered her subject was on the Civil War; next she recalled the exact assignment read, "A house divided against itself cannot stand." Finally, she connected this maxim with her parents' constant quarreling and her own terror. Soon she was helped regarding her real trouble, and relieved of the diagnosis of heart disease.

Our discussion topic is of the very greatest immediate importance to me, as it points up the greater part of my departmental planning. The clinical practice of psychiatry, of necessity, is in the hands of *every* physician. Indeed, wholesome, considerate treatment of each other is every man's responsibility. It happens that we physicians have chosen it as our *official* task, as our life's work. We may consider it no idle prediction, but rather an example of scientific predictability, that what is now largely miscalled the *specialty* of psychiatry will be gradually accepted as actually extending into every single aspect of the practice of medicine.

This trend in our medical profession will, in time, necessitate a very different allocation of our pre-medical, medical, and postgraduate medical study. The problems of medicine are of the first importance, and we are growing so rapidly that a standing curriculum committee must keep on the move to prevent our paying medical taxes without representation, to prevent our blind devotion to untimely detail and perfectionism in one medical area at the cost of neglect to first principles in another medical area.

Meanwhile, in our efforts to serve the people we must go on relying largely upon the literally heartbreaking efforts of men and women like yourselves. It follows, therefore, that the psychiatrist has the best of reasons for the warmest interest in the heroic work you are doing. Therefore, may I first of all pay proper tribute to your valiant, and so largely unaided, psychotherapeutic aims and achievements.

Let us conceive the whole field of science as world antennae or "feelers" sent out from our base of tested and proved human values to find directions most worthy for human progress. Medicine is in the vanguard of this human pioneering movement. Psychiatry is an integral force in the *meaning* of medicine, permeating it with the dignity proper to its official concern with "the humanity tissue."

The whole world is beginning to awaken to the economy of prevention of illness and to the extravagance of not intending, not planning, health. This evolving world program will have to rest firmly upon the shoulders of the practicing physician.

Twenty-five hundred years ago Socrates made the connection, and offered the hint to the world, "The body cannot be cured without the mind."

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*A recollection of Dr. Joseph Walsh, quoted by Dr. Harvey Cushing in *The Life of William Osler*, page 490.

In the last century, Charcot gave us our indispensable insight on the "organicity of the idea." Freud, a pupil of Charcot, prosecuted this hypothesis with all of his genius.

Today, all you and I need to do is to consider the reach of the autonomic and central nervous systems and their mental connections to sense for ourselves the inevitability of Socrates' words. Any kind of danger, or "supposed" danger, to our patient can let loose the anxiety that in turn can act like a trigger for the discharge of our patient's nervous energies.

We are all aware that the time is propitious for all medical men to understand the general implications for public health in the discoveries of developmental psychology. Every physician is entitled to discipline his mind to respect the basic principles of dynamic psychology.

In developing the topic, "The Application of Psychiatry to the General Practice of Medicine," there are many approaches that might be employed. The time alloted for discussion, it seems to me, is best dedicated to the treatment of the following four considerations in the broadest of terms:

1. What is psychiatry?
2. Is it possible to exclude psychiatric treatment from the general practice of medicine?
3. What are the obstacles to applying the therapeutic agents of psychiatry?
4. What constructive hints can we, as medical men, derive from this session?

What Is Psychiatry?

Literally the word *psychiatry* means treatment of the mind. We define mature mental health as the ability of the mind to express itself in the best interests of our whole self. By the same token, we define mental weakness and illness, as the necessity for the mind to express itelf in ways that are detrimental, injurious, to the whole individual. *Psychiatry, then represents the treatment of misbehavior, misconduct, and self-expression that is injurious.*

We have learned that we cannot expect the child to behave as an adult can. The child's mind is not integrated sufficiently to be able to represent his whole person well. Thus, the child needs help in behaving himself. The word "behave" is made up of the auxiliary verbs "to be" and "to have." The injunction "behave yourself" involves: (1) acknowledging all of your self uses, that is, "be yourself," and (2) self-possession, that is, "have yourself."

From these generalizations we cannot help but see a relationship between the well mind and the good mind. If we are to enjoy wellness of mind, we must live in such a way that wellness of mind will have to follow. Just as the church teaches that it is necessary to practice goodness, so the psychiatrist has found it is necessary to practice wellness of mind, if we will have it and keep it.

In all ages, people have been struggling blindly with mental illness, calling it by many names such as crime, slavery, private capitalism, competition, or a distant country. We have had no clear idea of the true nature of our opposition. We have had absolutely no more insight than children of the effect of mental illness, its root meaning for human relationships, its ubiquitousness in homes, industry, schools, and yes, churches. We have wasted our strength, and suffered accordingly, in attempting to cure ourselves by straightening out society or something else, one way and another.

About one hundred years ago, medical educators rather suddenly withdrew from centuries of concentration upon natural philosophy to invest their attention in natural science, with the result that psychological data came to be regarded as abstract and unsuitable for scientific work. They were neglected as "imponderables" and "intangibles." Thus, the truth was thoroughly overlooked, that mental data are the *only* concrete self data that we have, and represent the *only* materialistic facts of our immediate experience.

Psychiatrists believe that where there is function there must be structure. However, our attempts to correlate pathological-anatomical findings with mental symptoms, and our efforts to establish the "material" substructure of mental functioning, have gone on very much at the expense of respectabilizing work on the psychological level of the body. The operation of psychological causes were turned over to the live minds of the clergy and men of letters. These workers with mental agents were not to be dissuaded from their convictions of the existence of organic mental causal sequences. Indeed, we might do well to leave the troublesome responsibility and the management of mental operations entirely in the capable hands of our clergy, were it not for the fact that we have no choice in the matter. We medical

men must, perforce, work with our fellow man intimately; we must, perforce, cross the sacred portals of his private life, and invade the sanctity of his home. Advancement of psychiatry is a triumph of moral forces. Our personal limitations as psychiatrists are, at once, our burden of reproach.

Can Psychiatric Treatment Be Excluded From General Practice?

Down through the ages, the physician has recognized the necessity to know not only what kind of an illness a person has, but also what kind of a person has that illness. Again and again he has noted that one person will die of seemingly the same kind and degree of an illness which does not even keep another man in his bed. Today the medical profession recognizes that whether or not the physician wishes it, he has no other choice than to add the practice of psychiatry to his complete medical workup. The only choice left to him is whether it shall be superior or inferior psychiatry. Perhaps as much as any leader in the community, the physician is busy in the area of human relationships. The prophylactic psychotherapy that you practice from the start of your patient's illness, just through your sympathetic attention towards him, not necessarily understanding his mental sickness, is *major* psychotherapy. The patient, ill for whatever reason, comes to his physician not only apparently asking for human leadership, but really ready and requiring to be led.

It is essential for therapy that physicians be as alive and interested in living as possible. Being alive to the *human* element in disease is essential to the practice of medicine. Our need to concentrate upon the visible foci of illness tempts our attention away from our patients' less perceptible, but no less real, concurrent mental needs. At times our hospital allusions to "a heart on II North," "a fracture on II South," "a kidney on II East," and "a liver on II West," may too accurately bespeak the sum of our active concern about our patients. "There are no illnesses, there are just sick people" errs in its exclusiveness, in the opposite direction. *Cymini sectores.* There *are* illnesses, and there *are* human sufferers.

Abeunt studia in mores. And because studies do pass into manners we must be mindful of the lesson we set. Undergraduate students need to be alerted to common psychiatric booby traps awaiting the unwary in general practice. For example, it is conceivable that general practice patients whose warped personality dictates "ask for" ill treatment, might gravitate to physicians who are unable to defend themselves against unwittingly fitting into such a sorry regimen.

The general practice patient who can respond most effectively to expert attention to his inordinate mental needs, as these excessive tensions are forced by his nonmental illness, provides the most promising clinical material for preventive psychotherapy. There is the additional incentive to help attend to this patient's mental strain in that he can, most readily of all, be helped to help himself. The minds of these "ready" selectees for preventive psychotherapy are, to be sure, excessively burdened, but not yet twisted into organized pathological mental configurations as a source of relief. Mental changes that commonly accompany our nonmental illnesses result in weakened psychic integration expressed in our diminished capacity to consult our own best interest and lessened ability to share.

Let us review some of these changes, noting how they illustrate the mind's antagonistic tendencies: accesses of anxiety, usually expressed in lessened self-confidence, or in "recklessness"; discouragement, usually expressed in "What's the use?" reactions or in "carelessness"; irritability, usually querulousness or "injured" feelings; difficulty in concentrating, usually inattentiveness or distractibility; impaired judgment, usually heightened suggestibility or antagonism; initiative disturbances, usually increased ambivalence between excessive dependence and excessive assertiveness; emotional instability, usually numerous and sudden emotional changes or apathy; psychological fatigability, usually disinterest or "fighting" rest; sleep disturbances, usually insomnia or excessive dreaming; day dreaming, usually revived old phantasy systems or flights into perceptions; and many temptations to invalidism, usually less will to "carry on" or "going on nerves."

Preventive psychotherapy will consist, first of all, in doing the patient's mind no harm by unjustifiable probing into his mind to secure more information than we can use to advantage. Besides this concentration upon doing no harm, the psychotherapy will consist in providing the patient with accessible well minds to lean upon, to test his own mental strength against, and, in time, to help him refind his own reliable mental wings. Experience teaches that if we put to test our own mental

power to help our afflicted brother, we will find our work satisfaction in restricting our therapeutic ambitions to that which it is possible to accomplish. At times nonmental afflictions, even, may *seem* to cure mental ills.

Will you please consider with me that it is now time for us to take one more step forward in our progress of medical truth? We medical men no longer need justify our interest in psychotherapy only by quoting the high percentage of our "psychoneurotic" patients. We may observe in all truth that the mind of our patient is affected, *in all illness.*

The sick mental organ can interfere with the normal functioning of other organs which then develop their own autonomous ills. More than this, the relationship of the mind with the rest of the body is a reciprocal one. Thus, when any part of the body is hurt or ill, the mental forces rush to its protection much as do the defense mechanisms in the blood stream. For example, the sickened part becomes a focus of attention. The interest invested in the part tends to favor it, to "spoil" it. The part takes on additional meaning. It becomes for a time a psychological center, and exerts abnormal influence as such.

The mind of man represents a powerful set of influences bearing upon all of his nonmental afflictions. Particularly, the great powerful mind enters into the disorders of its fellow human organs. For some time, I needed for my medical research a demonstration unit in which we might keep before ourselves the efficacy of respecting the mental component of all of our illnesses that have their sources in nonmental noxae. Happily, this need has recently been met through the McGregor Health Foundation's offering to our Department of Psychiatry its Convalescent Home facility for this very purpose.

What Are the Obstacles to Psychotherapy?

In the first place, psychiatrists, beginning with themselves, are all agreed about the universality of mental illness.

Secondly, there is general agreement that mental illness always involves the most intimate, the most personal, the most private problems of every individual. We regard these problems as matters calling for such great confidence that frequently we do not let ourselves in on them. Almost as if by unwritten law, or gentlemen's agreement, or unspoken common consent, we condone the secrecy shrouding them. Thus, there results a kind of secret pact to defend each other's rights to mental illness. Thus, without quite knowing all that we are doing, we set up obstacles to strong-mindedness, proper feeling, and straight thinking. Resistance is generated and mobilized against the "letting out" of our mental troubles. The very acknowledgment of mental trouble is stigmatized. Yet a person's "nervous breakdown" commonly represents the clearest expression of truth that he has permitted himself during all of the time that he has kept up a front of spurious mental health.

The psychiatrist is asking himself if he is not "paying too much for his whistle" in saving face in this way. At least we can do no harm to consider soberly among ourselves, the possibility that we medical men are up against a secret pact on the part of struggling humanity not to go to the doctor with mental illnesses because it would hurt too much.

Our professional life is spent entirely in observing people bringing their hurt minds to us and protesting against their feelings being injured further. Their finer sensibilities already have been outraged too much. That is their chief complaint. They need to have their better self supported, fortified. Consider that finding against the background of how much they have found painful in their world before they seek, or are brought to, the physician. Each one of us walks around a bundle of vested interests, both successful and unsuccessful in making headway for that reason. The physician can be taught that he has no choice other than to be a physician of the mind, along with the rest of the body. Whether he will or no, his mental attitude towards his patient has the weight of a prescription.

Medical students are, for purposes of conventional education, tractable enough. They sense in medical psychology courses, however, much that they are inclined to slight as "beyond the call of duty." Opposition to the representations of mental health is as a rule, not ordinary, but factious. "Sour grape" rejection is the lay term for disdaining the truth. We encounter resistance in trying to share our credo with our medical students: "I believe in everything that there is, and I believe in finding its best use."

However, we shall be successful if we can get our undergraduate students to develop partial insight around the fact that successful physicians owe their rise quite as much to the integrity of

character they bring to their medical training as to the training itself. For example, let us help them to see that all of their professors and all of their leaders in medicine owe their leadership not only to what kind of medical teaching their persons were exposed to, but also to what kinds of persons they were, and were becoming, while exposed to the medical teaching.

It is one thing to talk principles of mental health, and quite another thing to live these principles ourselves. Someone has said that the principles of mental hygiene are readily applicable to "somebody else." We physicians are very much in the position of clergy, of confronting ourselves with the necessity to strive to practice what we preach. Useful expressions are occuring, and recurring to us, such as "The blind leading the blind" and "Physician, heal thyself." *The long and short of it is that the practice of wellness of mind is a stern discipline.*

Medical students can have their minds disciplined in the direction of recognizing the opportunities that the general practice offers for practicing preventive psychotherapy, especially on the very young mind, as yet, relatively unspoiled by misuse. Dr. Raymond W. Waggoner has worked out an exemplary training plan for increasing the mutual usefulness of psychiatry and the general practice. He is preparing members of his staff to represent psychiatry in its fellow general hospital services.

Let us learn, in time, to build upon the firm ground of: What else is there that is more useful to do? Hard conditions, that are not too hard, are favorable to mental development. In all truth, we do not see how we could get on without what Carlyle termed our "black monster, falsehood, our one enemy in this world." Without temptation, the meaning "on duty" would have no blood in it. The value of falsehood for truth; The value of concealment for revelation! Not many of us have an eye for the obvious, for open secrets. The world will always offer enough want and wretchedness without our forcing our ignorance upon it. Let us not go on cultivating human depravity that perceives no connection between the sun in the sky and its reflection in muddy waters, between the world outside and worldkin within. And cause and effect, the two hands of God, all the while holding all together!

The world is so full of a number of things it behooves us to be sure that we are looking at what it pays us most to look at, and, then, make sure we see what we are looking at. The facts of mental illness are most worth looking at. We know some helpful facts already. There remain great gaps in our knowledge. If these gaps are not filled, our homes, our churches, and our schools must go on suffering the awful consequences. Of all life's hardships those that most need attending are those that are hardest to mind well: mental defects, mental weaknesses, and mental diseases.

The teaching of medical psychology will involve much standing and waiting and holding peace. There is much to be learned about incentives to effort. It is fitting that we make medical ideals known. If they do not appear to "take," they are nonetheless forceful. Sincerity is all that will work on those who have fled feeling and become case hardened with protective callus.

The truth about a patient is denied the physician who cannot *feel,* composing (integrating) himself under the strain of feeling. Confronted with the choice of appearing either maudlinly sentimental or "unfeeling," his choice may be the latter. Even more reprehensible than asking our medical students to "think" on their own, we must ask them to "feel" on their own. The consequence of our mind's inability to sustain feeling is weak understanding. The greater its understanding, that is, its acceptance of the necessity of a presenting circumstance, the more our mind is able to be aware of the participation of feeling in it. Understanding that is bereft of feeling is shallow and hollow. Our deep and solid understanding involves an effective compromise of our vital emotional forces, not an absence of them. Mutuality with our clinic, with our world, is a gift of feeling.

Medical studies require that the students take upon their, as yet, young, tender, and unready minds, the heaviest emotional burdens of our existence, the full weight of our suffering humanity. Long before most of them are able to "keep their heads" under the circumstances, medical students are called upon to "hear confessions" of all kinds of human weakness of the mind as well as of the less intimate parts of the body. Some students actually lose consciousness, or even stop school entirely, upon first entering the dissecting room; and varying degrees of unpreparedness for most exacting assignments exist in all of us. Most commonly the first quarter examinations disclose the student's intentions to attend medical school with reservations. Little wonder that medical students

so commonly overlook patients' mental injuries. They get their fill of *rubor, calor, tumor,* and *dolor,* without coming still closer to the patient to see truly how heavily laden is his humanity tissue, his mind, with all its torturing ills.

Contempt for sober consideration of whatever is, is second to no contempt that we know of. To refuse the consideration of feeling, to become "uncaring," is most dangerous of all in the physician. Historically we are familiar with contempt for reason and science. Contempt for the finer feelings on the part of the physician, whose mind has not yet been strengthened enough to contain them, is a chief source of mistreatment of the mental structure.

The medical psychologist has a scholastic tradition both to draw upon and to combat. Very few colleges' psychology courses offer him much help, except as salient contrasts. All of us speak of "education" as our great hope. The kind of "secular" education that has been common so far is a start of sorts. If the problems of acquiring, sharing, and keeping mental health were simple of solution, they would have been long since accomplished. For so many of us, our whole life does not make sense to us. We are unready for our difficult world. It is human to try to solve our difficulties in ways that appeal to our needs for sodden ease. It is human to protest against the exertion called for in up-and-coming hard work. But if we can help our medical students not to harm their patients' minds, as much as they might if they were not forewarned, that gain may well be likened to progressive medical education.

Truly the physician has no choice other than to go about doing well, or ill. His life is not obscure. It is beneficial for the medical student to discover, early, that his behavior as a physician will exert far greater influence in his community than he might be inclined to consider. Let us examine how we may succeed more in addressing ourselves to the development of ways of acquiring and sharing mental health. It is the psychiatrist's vocational necessity to work every day upon keeping and improving his own mental health.

The rank of honor bestowed upon the physician is derived from the fact that his profession directly concerns *human beings.* The fact that the doctor works upon *human* lives is the source of his professional greatness. The medical student who falters in honoring his patient's humanity, "the grand tissue of all tissues," is undermining the ground upon which the greatness of medicine is elevated. He is like a man sawing off the limb of the tree that is supporting him. Who is not honoring humanity is dishonoring humanity. As Saint Chrysostom observed, "the true Shekinah is man." It is with this "architectural idea" that we can further the development of training in "the humanities" in both pre-medical and medical education.

What Hints Can Be Derived From This Session?

May I venture to list six most important ways in which psychiatry can be applied to the general practice of medicine.

First, our very careful medical workup of the patient is best undertaken with good insight that his mind is the highest level of integration of his body. Many practicing physicians already examine their whole patient. They secure the history of the development of his every incapacity in terms of meaningful personal events in his life, such as the real and threatened comings and goings of his life —the births, deaths, marriages, separations, financial swings, and similar gains and losses.

Second, the basic precept of psychotherapy is to do the patient's mind no harm. Every physician recognizes the truly great personal influence he has upon his patient. Particularly the best physicians do no unjustifiable probing into their patient's mind. They are careful not to get more personal information than they can use to the patient's advantage. They acknowledge the wisdom of the human body to the extent of realizing that even the patient's mental illness has elements of self-protection in it. Therefore, they will not take any defense away from their patient without having a superior one to offer.

Third, the family physician has access to the nursery of mental health, the home, and can represent to the parents that the baby has a mind, that what happens to the baby also happens to his mind, that there are community resources that can help the parents to understand the nature and needs of the mind of the infant and child. The obstetrician can get in many an enlightening, encouraging and reassuring insight and attitude to the bewildered expectant mother. The pediatrican can prescribe much psychological medicine in supporting, and not despairing over, the innumerable tragic mental influences in the homes he visits.

Fourth, time and again psychiatrists have observed their patients recover health mainly through

the psychiatrist's listening to him speak his mind, have "his day in medicine." The attention of the physician to the patient and of the patient to the physician represent sources of therapeutic power all too seldom recognized as such. "Paying" attention, "investing" interest, can and does relieve the patient's mind, effect mental repair, and make the physician far more meaningful to the patient. Patients, ill for whatever reason, are particularly susceptible to the healing effect of attention devoted to their mental needs; they are also particularly susceptible to the injurious effect of deprivation of attention to their mental needs. Attention to mental needs is not "beyond the call of our duty." Hence, the awful predicament of the young medical man whose mind needs further strengthening before it can well sustain mortality's cruelest threats. Attention may be described as the breath of mental life.

Fifth, the practicing physician has awareness of *every* patient's anxiety, dependence, suggestibility, and seeking of leadership; and he has due respect for the necessity of these changes as well as for the opportunities they offer for preventive psychotherapy. He applies the following human values as wonderful remedy: basic friendliness, goodness, and decency; free interest, undivided attention; genuineness; self-respect; industry, exertion of healthful concern regarding his patient's welfare; proper principles and ideals of service, self-possession, and good citizenship.

Sixth, the practicing physician represents, above all, a potent community influence directed towards the development of improved community mental health values. May we physicians represent in our own behavior our own intention to be interested constantly in self-improvement, in self-betterment. Most physicians are living symbols of proper self-management. A safe mental hygiene rule to follow in being helpful to patients is to strive to be more informed, and to be able to care more, about the patient's behavior. Psychotherapy, let us recall, applies to behavior. To recognize ourself in our patient is to be properly, fitly related to him.

Conclusion

Preventive psychotherapy, the great hope in psychiatry, can be realized in general practice in the effective use of psychiatry in the patient suffering non-psychological-level illness, *before* his undisciplined mental reaction to this illness has had opportunity to mobilize into a sickening of mind. The uninformed mind, if unaided in working out a healthful formula, may develop a morbid formula, for getting along under its adverse circumstances.

Working together in the general practice of medicine, all of us can approximate our goal of preventive psychotherapy *at a time when mental illness is known to be an immediate formidable threat.* Psychotherapy represents a great extension of medical practice. However, psychotherapy will prosper if it is used in a different way from that which is current today. Too often the patient turns to the psychiatrist after all other medical means have failed him, and the psychiatrist may use *only* mental therapeutic agents. Both exclusive rationales can be disadvantageous for our patient. The general practitioner, internist, surgeon, pediatrician, and all specialists can best apply psychotherapy *from the beginning of every illness* to its finish. Psychotherapy is applicable to, and efficacious in, all human illnesses. It belongs in the physician's medical armamentarium, along with all of his other therapeutic means. Particularly regrettable is its application as a last resort, and even as a turning away from scientific procedure altogether. For the good of all of us, it is necessary that we protest against all artificial "boxing off" of any one part of our profession from another.

May I end, as I began, with proper tribute to your great courage in "carrying on" and advancing your psychotherapeutic efforts against the terrifying odds of the universal unreadiness for basic mental health representations. May I express my ready recognition that all of you have been "doing" psychotherapy and doing it to the best of your ability. I know well of the great obstacles you have been courageously contending against, and I know that it is this particular psychotherapeutic aspect of your practice that is taking the greatest toll on your energies and on your right to your share of peace of mind. The proper physician, we are all agreed, is he who knows his own practice not to the exclusion of, but rather in relation to, other branches of the profession.

May we consider the possibility that, in time, every general hospital may develop its own practical kind of psychiatric in-patient service, after the pattern established by Dr. Thos. J. Heldt.

The Clinical Aspects of Physical Medicine

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It is realized that it is impossible to cover this subject in the space alloted for this paper, but I will attempt to present a few of the clinical aspects of physical medicine as now recognized by the various specialty boards, the American College of Physicians, the American College of Surgeons, and the American Medical Association.

It must be understood that physical medicine is a specialty, the same as other recognized specialties, and that the physiatrist has to be exceptionally well-grounded in anatomy, physiology, physics, and neurology. He must continually be aware of the problem of the general practitioner, the surgeon, the internist, and the psychiatrist. He must be aware that kinesiology in its entirety is the difference between activity and vegetation.

Physical medicine embraces the fields of physical therapy, occupational therapy, and physical reconditioning. We who are engaged in the specialty of physical medicine believe that all patients are entitled to have their bodies and minds maintained in the best possible condition at all times. We do not wait until the surgeon, the psychiatrist, and the internist have finished treating the patient, but work simultaneously with them, thereby reducing the morbidity and returning the individual to productive society at an earlier date than could be expected otherwise.

Several years ago I became firmly convinced that physical medicine had a definite clinical application, the same as all other recognized medical specialties. And, as in all other recognized medical specialties, the majority of physicians do very outstanding work, some do mediocre work, and a very small percentage verge on being "quacks."

It was the latter group, plus the overly ambitious salesman of apparatus with his book of instructions, which drove various useful therapeutic devices now used by the physiatrist into a questionable category.

Many physicians bought diathermy machines without the slightest idea of what came out of the electrode, whether pads, plates or coils. They knew only that it produced a sensation of warmth, made the patient feel good and was a source of easy revenue.

Since physicians do not monopolize the brain market, a good many smart and ambitious laymen decided that here was a good way to make a living, so they proceeded to buy infra-red and ultraviolet lamps, long- and short-wave diathermy machines, whirlpool baths and any impressive "Rube Goldberg" apparatus they could find.

The factors stated above caused many physical agents, as applied to medicine, to fall into varying stages of ill-repute. Many ethical physicians shied away from that which the poorly qualified professional man had adopted for purely monetary reasons.

Many outstanding specialists in hand, neuroplastic and orthopedic surgery have long understood what baking, massage, whirlpool, manipulation and exercise could do within their own fields, and consider these adjuncts to recovery of sufficient importance to direct them personally and to investigate further into their uses.

The observing general practitioner, dermatologist, syphilogist and internist have noted that ultraviolet radiation produced a general increased tone in the patient's over-all condition, and that hydrotherapy combined with other physical measures, when properly administered, usually aided their arthritic and peripheral vascular patients as well as those suffering from fibrositis, tendonitis, and backache.

The patient who is so unfortunate as to contract acute poliomyelitis is almost entirely dependent in the beginning upon the physiatrist and his examinations and instructions to the physical therapist. Later, this treatment is supplemented by the occupational therapist. Even in the recent past, the orthopedic surgeon was called in to splint the "acute polio" at the onset of the disease, and by the time the acute symptoms had subsided and the muscle soreness was gone, the patient had a marked atrophy of the unaffected muscles that were splinted, as well as the affected ones. The splinted joints were in varying stages of fibrous

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ankylosis. This was the usual stage at which the patient was turned over to the physical therapist for treatment. Usually the results were not very spectacular, so the "orthopod" put braces on the patient, and he went through life with a severe disability. That was the accepted method of treatment until quite recently, when Sister Kenny came to the United States with a different concept of acute poliomyelitis and its treatment. She being only a nurse, many brilliant but rather stubborn physicians refused to have anything to do with her. She turned to a leader in physical medicine, Dr. Miland Knapp, of the University of Minnesota. Doctor Knapp observed her work at Minneapolis General Hospital, and with his experience as a physiatrist, combined with his knowledge of poliomyelitis, he wrote in the medical journals that there were additional considerations for all physicians to apply in the treatment of acute poliomyelitis.[1,2] Now when an individual is stricken with this dread disease, the physiatrist and his trained physical therapists are called in.

Under this new regime, the patient is possibly well on the way to recovery before the splints would have been removed under the former method of treatment.

This rather lengthy discussion on acute anterior poliomyelitis is presented, not to ridicule or belittle those reputable physicians in other fields, but to bring out the idea that, "the way it has always been done is not necessarily the best," and to point out that the progressive doctor of medicine must take care never to become so set in his ideas that he refuses to listen to another whose concepts may vary from his own.

The fever therapy machine had an era of popularity and in many instances was accepted by the medical profession as the ultimate in the cure of gonorrhea and for the treatment of central nervous system syphillis, but with the advent of penicillin, the need for fever therapy vanished, or so some think. Yet, the ophthalmologist is well aware that the patient with acute and painful iritis or iridocyclitis can usually be relieved of his excruiating pain in from two to five hours if his body temperature is raised to 105° F.[5] Without this assistance, there is little than can actually be done to relieve this pain, except sedatives, for as long as two weeks.

Those of us who have done considerable fever therapy work believe that hypo-endocrinism can be aided by generalized increase in body temperature. In addition, hyperpyrexia is an adjunct in the treatment of several other conditions.

We know that when we increase the body temperature there is a marked increase in the white cells in the blood.[3] Then, isn't it natural to suppose that fever is not due to an infection, *per se*, but is the body's attempt to fight the invading organism, and the only way this can be accomplished is by increasing the number of white cells and their phagocytic properties?

The physiological processes of the body in health and the varying degrees of pathological changes during illness are quite well understood by every qualified physician. Yet, the actual application of these principles is often overlooked.

The physiology of applying heat is easily understood and is an aid in interpreting the different reactions that follow its application to various parts of the body. The arm or leg that becomes more painful when radiant heat or diathermy is applied is already carrying all the load that those blood vessels can accommodate. To increase the metabolism of the part, which occurs when the temperature is elevated, throws an added strain on an already overloaded vascular system. This manifests itself as swelling or pain or both. The same applies to any part of the body.

Accordingly, when the patient complains that the heat treatments make him feel worse, and states that he just gets over one treatment when it is time to start another, stop applying heat and begin to search for the cause of the impaired circulation; it may be local, but perhaps it is systemic. At any rate, nature has given the warning signal; it is up to the physician to heed it.

To understand thoroughly the effects of heat upon the human body requires a keen insight into the physiology of the vascular and the sympathetic nervous systems.

The plastic surgeon always wonders when he should jump a skin-flap or cut one end of a tube loose from the body. He has established certain rule-of-thumb procedures which are usually effective, but the percentage of total or partial failures is far too high; every plastic surgeon will agree to this statement. The problem is, "When is a graft ready to move?" and the answer is, "When the remaining blood supply will support it." And there the plastic surgeon runs into a stone wall; he has only his professional judgment to guide him.

I believe that the physiatrist using a multi-outlet thermocouple, together with his understanding of

the physiology of temperature changes as transmitted by the vascular bed, will be able to tell the plastic surgeon when the time has arrived to move the graft with an assurance of continuation of adequate circulation.

The "don't's for applying heat are:

1. Don't apply heat in acute inflammatory conditions. This tends to exaggerate the exudate and later interfere with the flow of blood.

2. Don't apply heat in cases of advanced peripheral vascular disease. If the heat cannot be carried away by the vascular system, the patient is readily burned.

The physiologic effect of cold, while not generally as widespread in application, is becoming more important with the increase and ease of long distance travel. Particularly at present, the nations of the world are looking toward both the north and south poles. We Americans found out during the winter of 1944-1945 that we were not prepared, medically or otherwise, to meet the problems of cold weather operations. The high incidence of trench foot illustrated this point. Once the clinical symptoms of trench foot set in, little could be done about the condition.

Therefore, we of the medical profession should turn to this subject and make a pronounced effort to understand it as it pertains to physiology and pathology.

In making a quick review of the therapeutic application of cold, often called "cryotherapy," it would perhaps be easier to list the salient points:

1. The employment of generalized cold has not been established, as yet, as a rational therapeutic procedure. (It has been advocated by some for advanced malignancies.)

2. Until the physics of cold is better known, understanding of the physiological effects of cold will be retarded.

3. The chilling of a member of the body diminishes the rate of circulation markedly, and in time the temperature of the deeper tissues will be only slightly above that of the source of cold. (This is the explanation of anesthesia by freezing that is used in certain amputations.)

4. Normally, exposure to cold causes a vasoconstriction, but exposure to water of 41° to 50° F. for five minutes will produce vasodilatation, and the skin becomes bright red. This change is brought about partly through nervous reflexes.

5. The application of cold to one extremity may cause vasoconstriction to another part of the body. This may be on the skin surface or the mucous membrane.

6. When cooling results in prolonged peripheral ischemia, not only does this ischemia affect the mucous membranes, but also it "serves to throw out of balance the nicety of integration existing under normal metabolic phases and accounts for the ability of ordinary avirulent organisms to overcome the obstacles of tissue immunity at portals of entry."

7. Ordinarily, cold produces vasoconstriction but when the skin temperature is below 64.4° F., there is a reflex vasodilatation of the skin to a mild inflammatory reaction. This reaction may protect the peripheral region from injury.

8. Local applications of cold are indicated chiefly in the treatment of conditions in which local vasoconstriction is desired. Among these, the principal ones are contusions and sprains in which the trauma has been sufficient to cause danger of, or actual extravasation of blood and lymph into the tissues. Immediately after such an injury and for twenty-four to forty-eight hours succeeding, continuous local application of cold is indicated.

9. Desensitizing the patient who is sensitive to cold is easily accomplished by having the patient immerse one hand in water at 50° F. for one or two minutes twice daily for three or four weeks.

Light therapy and the use of the diatherm will be considered together because to understand them the same principle is applied, that is, to realize both are a consideration of wave length and frequency.

All waves travel at the same rate of speed (299,763,447 meters per second); therefore, the frequency increases as the wave length becomes shorter.

For convenience of application of the shorter-length waves, the ängstrom unit is employed. (An ängstrom unit is 1/254,000,000 inch or 1/10,000,000 of a millimeter.) This is used in ultraviolet therapy and is designated as A.U. or A°. The ultraviolet waves of 2,400-3,170 A.U. produce erythema of the skin, while pigmentation is produced by waves of 2,800 to 3,000 A.U. Ultraviolet waves are the catalyst which activates the ergosterol in the skin, into autogenous Vitamin D.

Some of the indications for ultraviolet radiation are (1) rickets, (2) tetany, (3) osteomalacia, (4) demineralization of the pregnant and nursing

mother, (5) lupus vulgaris, (6) pityriasis rosea, and certain types of nonpulmonary tuberculosis.

The wave lengths of diathermy machines are now controlled by the Federal government so as not to interfere with radio transmission.

The physiological effect of penetrating heat (diathermy) is to increase the blood supply to the part heated, thus relieving pain and promoting leukocytosis. This will indicate to the physician the greater number of conditions for which short-wave diathermy may be indicated: (1) Intermittent claudication, (2) chronic myositis, (3) nonmalignant pyloric obstruction, (4) chronic prostatitis, (5) acute laryngitis, and (6) non-obstructive sinusitis, to name only a few.

The indications for infra-red radiation are, (1) arthritis of the smaller joints, (2) contusion, (3) joint sprains, (4) superficial myositis, (5) tenosynovitis, and (6) neuritis.

Low voltage electrotherapy and electrodiagnostic procedures are carried out with the sine wave, pulsating direct and galvanic currents. These currents are of use in producing involuntary muscle movement, and smooth, rhythmic muscle exercise and massage. Positive galvanism causes a contraction of tissue and vasoconstriction, whereas negative galvanism relaxes and softens tissue and causes vasodilatation.

Electrodiagnosis is the electrical testing of muscles and nerves, and has become a most valuable aid in the diagnosis of conditions where partial degeneration of the nerve and muscle fiber is suspected. The importance of one's ability to determine the actual functional activity of individual or groups of muscles by electrodiagnosis, for determination of the degree of paralysis, the reaction of degeneration, and in medico-legal conditions which are likely to arise in a physician's practice, cannot be overestimated.

Conclusion

It should be stressed that physical medicine is a recognized medical specialty that is closely associated with surgery and internal medicine, yet does not infringe upon either. As a general rule, the physiatrist aids the surgeon and internist in increasing the rapidity of recovery of their patients, or continues treatment after their services are no longer required.

Physical medicine, as now recognized, resulted from necessity during World War II. The conservation of manpower became vital to the welfare of the nation. Likewise, it is now recognized by the progressive physician that the conservation of our productive potential, as pertains to the civil population, rests in the close co-ordination and co-operation of the surgeon, internist, psychiatrist and physiatrist. The sick or injured man or woman who can be sent back to work earlier, and in better physical and mental condition, is an important asset to the national economy.

The helpless and hopeless invalid who can be made financially self-supporting is a boost to humanity. It has already been proved that certain types of invalids of many years' duration can and have gained economic independence, with the aid of physical medicine.

References

1. Cole and Knapp: The Kenny treatment of infantile paralysis. J.A.M.A., 116:23, (June 7), 1941.
2. Knapp, M. L.: The Kenny treatment. Arch. Phys. Therapy, 23:668, (Nov.) 1942.
3. Krusen, F. H.: Physical Medicine. Page 61. Philadelphia: W. B. Saunders Co., 1941.
4. Taylor and Dysenforth: J.A.M.A., 111:1744-1747, (Nov. 5) 1938.
5. Vorisek: Evaluation of nerve therapeutic agents. Am. J. Ophth., 30:1, (Jan.) 1947.

MSMS

STOP—LOOK—LISTEN

STOP telling the patient there is nothing wrong with him but nerves—Don't say: Go home and forget it.
LOOK for the facts as the patient sees them.
LISTEN attentively to the patient's story.

The incidence of intellectual and emotional disorders has been found to be consistently smaller among eminent men and their families, than in the general population.

Individuals of lower intellectual status usually come from inferior social, economic and educational levels.

Hysteria is found in individuals of lower intellectual levels than those suffering from anxiety states, which in turn occurs in those of lower intellectual levels than sufferers from obsessions.

An abnormal environment will produce an abnormal child.

Children learn more from example than sermons.

Emotional stress in the home may drive the individual out of the home into criminal associations.

Shock treatment is only a part of treatment.

Psychotherapy for the average patient is not a mysterious, complicated procedure. It is a re-education. It is a teaching of the patient how to live, to meet and to plan a life.

MENTAL HYGIENE COMMITTEE, MSMS.

Early Recognition of Carcinoma of the Colon and Rectum

By Louis J. Hirschman, M.D., F.A.C.S.
Detroit, Michigan

INASMUCH AS THERE ARE very few pathognomonic symptoms of cancer of any of the abdominal organs, particularly of the digestive tract, any individual, regardless of his age-group, who reports any deviation from his normal physiological trend of living should be considered as a potential victim of malignancy.

In other words, every patient who thinks he has indigestion, either gastric or intestinal, constipation or diarrhea, or so-called "gastritis" or "colitis" deserves a diagnostic checkup in order to determine whether or not there is some early detectable lesion which may be one of the warning signals of early malignancy.

Too often these days, patients are delayed from seeking medical advice for their ailments, because as they listen to the radio, some blatant, strident, persuasive announcer tells them all about the wonderful effects of Whosit's alkalizer, laxative or combination which relieves "excessive gastric acidity" or gives "gentle laxation," and "whether spelt frontwards or backwards" should be taken by patients over thirty-five, because of the "irregularities of intestinal function." With these gems of advice sandwiched in between soap-operas, singing commercials and sob sisters' heart-throbbing dramatics, the impressionable listener, particularly of the gentler sex, is often thus persuaded into a vicious period of neglected self-treatment.

Many an untimely death from carcinoma of the digestive tract, particularly of the large bowel, has occurred because the patient was radio-persuaded past that point at which an early malignancy could have been removed surgically, letting the patient continue on to his natural life expectancy again.

Too often, patients who showed symptoms of intestinal irregularity and noticed the passage of some blood from the anal orifice have been advised by their druggists and, unfortunately, by some unthinking physician, that all that they needed was to insert a few suppositiories or use some hemorrhoidal ointment and the symptoms would subside. Hardly a week passes but such individuals are encountered, and our experience is no different from that of many other proctologists.

Too often, patients who may have diarrhea or constipation, or who may have hemorrhoids or some other ano-rectal lesion, are also afflicted with carcinoma located higher in the bowel, and it is these patients whose hope of future relief is wrecked by their self-treatment or by counter-prescribers, irregular practitioners and, unfortunately, careless doctors of medicine.

Symptoms which should suggest an early proctological examination, which should be a part of every physical checkup, are:

Change in intestinal habit, such as irregularity.
Loss of appetite.
Lassitude.
Indigestion.
Abdominal distention, relieved by the passage of considerable flatus.
Increase in intestinal activity.
Passage of mucus, later streaked with blood.
Hemorrhage, either slight or massive.
Gradual loss of weight, and later pain.

The patients who come in complaining of loss of 10 to 20 pounds of weight, lassitude and fatigue on comparatively moderate exertion, who have frequent bowel movements containing blood and mucus accompanied by considerable abdominal colic, or alternating constipation and diarrhea, are not afflicted with early carcinoma of the colon but are *late* victims of the disease.

The symptoms above mentioned are usually those of *impending dissolution.* In too many of these patients their chance of permanent relief through surgery and radium therapy have passed.

Carcinoma of the right half of the colon, as a rule, is characterized by the earlier appearance of anemia and an earlier showing of signs of disturbed bowel activity than is carcinoma of the left colon. The physiology and circulation is somewhat different.

The first evidence one notices in most patients is some change in the physiology of the gastro-intestinal tract, which may include gradual in-

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Dr. Hirschman is emeritus professor of proctology at Wayne University College of Medicine, Detroit, Michigan.

creasing loss of appetite, gas, indigestion and a change in the normal physiological regularity of peristalsis. The patient may notice either gradually developing constipation or may think he has colitis because of a gradual increase in frequency from his daily one or two movements to twice that number or more. If he complains of an increasing amount of flatulency or says that the flatus expelled has an increasingly offensive odor, which may or may not be accompanied by a slight amount of bleeding or a frank hemorrhage, that patient deserves a complete proctological study with special emphasis on fluroscopy of the colon, as well as films before the injection of barium suspension and after it is expelled. After the barium has been expelled, the inflation of air for contrast films should be an important part of this examination.

Before any patient is sent to the roentgenologist, he should have a complete anoscopic, proctoscopic and sigmoidoscopic study.

Time does not permit a detailed description of all the various symptoms which should be considered for this study. More than two-thirds of the tumors are located in the sigmoid, recto-sigmoid and rectum. Approximately four out of five lesions of the latter can be reached on digital examination; while almost all of the remaining 20 per cent can be seen through the sigmoidoscope.

Let me repeat again that these examinations should be made before the patient has a roentgenological examination, because so often the pathologic condition can be detected by visual methods and the roentgenological examination becomes corroborative or may present other secondary filling defects higher up in the bowel.

One thing one must always bear in mind is that carcinoma of the colon is not, by any means, an affliction of old age. In personal practice we have seen patients from fourteen to ninety-six years of age suffering from large bowel carcinoma. There is nothing more misleading to the physician, who would be on the lookout for early symptoms of carcinoma, than the expression the "age group." While it is true that most cases of carcinoma appear in the fourth or fifth decades, one must not be led astray by dismissing such a potential diagnosis when dealing with patients in younger age groups; the prognosis is so much worse in the younger victims that early diagnosis is of the greatest importance in this group.

(Continued on Page 723)

The Policy of Excess

By R. Wallace Teed, M.D.
Ann Arbor, Michigan

It is a commonplace that many of the policies of the armed services are time-worn and moth-eaten, but none of them appears quite as glaringly antiquated as that regarding the strength of the Medical Corps.

Up until shortly after World War I, the services demanded seven medical officers per 1,000 personnel, but at that time the ratio was reduced to 6.5 per 1,000, and has remained at that level since. This means, that in peace and war, the Army and Navy demand *one physician for every 154 personnel.*

The average for the country at large has never exceeded 1:750, and in a number of states in peacetime, the ratio had seldom gone below 1:2000. In Michigan at present, it is about 1:800.

During World War II, the services were unable to procure their full demands, but did recruit enough physicians to attain a ratio of about 1:250. At the same time, the number of civilian physicians was reduced, so that the country-wide average fell to about 1:1750. Thus, the services had approximately seven times as many doctors per 1,000 as the civilians—this in the face of the record that there were more civilian casualties than military.

The Army and Navy demands are apparently based on the theory that every unit would be committed to combat at the same time. That this is illogical is proven by the fact that in neither of the past two wars was more than 15 per cent of the total force available committed at any one time, and this is the history of practically all wars of modern times. Yet the other 85 per cent of the force is manned medically as if it too were to be committed at the same time.

Likewise, these demands have taken no cognizance of modern improvements in transportation and therapy. It is a simple matter to convey a medical unit from a pool in the rear to a combat unit at the front in a matter of a few hours, but rather than do this, the services kept hundreds of

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medical officers immobilized and idle for months. The time necessary for the treatment of many common conditions, such as gonorrhea, pneumonia, appendicitis, compound fractures, infected wounds, et cetera, has been greatly reduced in the past ten years, but this improvement has not been reflected in any reduction in the size of the Medical Corps.

An illustration from personal experience will point up the stupidity of this policy of excess. Base Hospital No. 19, with twenty-seven medical officers, was made up June 5, 1944, and eventually arrived at Tinian, Marianas Islands, on August 14, although the personnel did not go ashore until September 18. Construction of the hospital was started the following month, and patients were actually admitted on December 1. That made six months during which twenty-seven medical officers, eight Hospital Corps officers, and 400 enlisted men had absolutely nothing to do.

The following year, the Army decided to build a 5,000 bed hospital on Tinian, and work was begun in March, 1945. During April and May, five general hospital units, comprising about 325 medical officers, 1,200 nurses, and 4,000 enlisted men, arrived, and from then on, until November, did nothing. The plan was to complete the hospital by November 1, but it was apparently necessary to have the personnel there six months in advance, in order to watch the Seabees build the hospital. For this, and other reasons, there was an urgent need of doctors in the services! Any medical officer could give other instances of widespread waste of medical personnel, which, if added together, would total millions of man-days during the war.

On the basis of an experience of forty-four months in the Navy, it is my considered opinion that most of the stupidities practiced by the Navy stem from this policy of excess. The waste of manpower that was general could not have occurred had there been fewer medical officers available. The use of medical personnel in non-medical activities, such as correcting correspondence courses, teaching illiterates, handling money orders et cetera, would not have been possible. Likewise, the treatment of families of servicemen in urban centers, and other New Deal social policies, would not have been forced on medical officers had there not been so many of them.

This excess of medical personnel is bad enough in peacetime, since it leads to indolence and padding practices, but in wartime, it is criminal. On the one hand, it robs the civilian public of much-needed medical care, and on the other hand, it robs the bulk of the physicians in service of the opportunity of making a decent contribution to the war effort. I would estimate that during my seventeen months in the Pacific, I did about one month's work as judged by civilian standards.

In peacetime there are few military casualties, yet the 1:154 ratio is maintained. I believe the services owe the country an explanation of why it is that the healthiest group in the country retains five times as many doctors per 1,000 as the civilian public. The excuse of emergency holds no water, since civilian doctors are always ready to respond. In my opinion, it is a totally unmitigated waste of the public funds.

I am fully convinced that a ratio of 1:500 would be completely adequate for all service needs, considering the fact that in general, the Army and Navy accept only the healthiest people available. For noncombat units, 1:1,500 or 1:2,000 would be ample, and pools organized in rear areas could quickly make up the deficiencies of combat units.

It is obvious that the services cannot be expected to effect this reduction voluntarily. That is like asking a man to cut off his arm. Whatever reduction is made must come through Congressional action, which means joint pressure by all groups interested in a rational organization of the Medical Corps. The House of Delegates of the Michigan State Medical Society at its fall (1946) meeting instructed its offcers to present this matter before the Senators and Representatives of the state in Washington, and other organizations have acted similarly. Every doctor whose time was wasted in the service should make an effort to bring the matter before his society and urge it to act. With another war in the offing, it is inconceivable that we should carry into it the stupidities of the Civil and Spanish Wars; yet that is the probability unless action is taken soon. It would seem that the time is long past for the correction of this wasteful and criminal policy.

MSMS

SUPERSONIC-SPEED PROBLEM

When airplanes fly at supersonic speeds, temperatures in cockpits may rise high above that of boiling water because of heat generated by friction, an Army air surgeon predicts.

Editorial

GENERAL PRACTICE

MICHIGAN'S DELEGATES to the American Medical Association for several years advocated the raising of the status of the general practitioner to a level to be recognized in hospitals and medical societies. Much work had been done here in Michigan looking to the greater advantages and opportunities of general practice.

A Section on General Practice has been added to the Michigan State Medical Society's list. The same has been done in the American Medical Assocation.

It is the hope that men will prepare themselves for general practice just as earnestly as they now prepare for the specialties. For all the recognized specialties, the course of preparation is long and difficult, but it is feasible and is being followed in ever-increasing numbers by younger graduates, and by some who have been in practice for years.

The medical colleges are endeavoring to play up the desirability of general practice as a calling for doctors, but with few choosers. The ideal in mind is to prepare the general practitioner in many fields so thoroughly that he will become a hope and a guide to patients. The term should indicate someone who has chosen to make the general field of medicine his specialty. The young graduate who has taken the required intern year, and then settles down to answer all calls is not a general practictioner in the light of the present effort.

The general practitioner, of the sections newly developed, will be prepared to do minor surgery and some of the major procedures. He will know how to recognize glaucoma and see that immediate proper treatment is advised. He will know when cesarean operation is advisable, and he will recognize this necessity early enough.

We confess a lack of understanding of just what this will lead to in the practice of medicine. We hope all doctors who do not choose a specialty (and those are getting fewer) will become well-prepared general practitioners. We are rapidly approaching the time when something drastic must be done to give our people the services of well-trained and conscientious general practitioners. In many of our cities the doctors of medicine who have taken up some specialty, and have done more than just proclaim themselves specialists have increased at an alarming rate. More than half of the doctors in one of our well-known Michigan cities are either Fellows of the American College of Surgeons, or have a diploma from some of the specialty boards. With some doctors becoming older and unable to make many night calls, and others just doing office practice, there are less than 20 per cent of the doctors, who classify themselves as general practitioners, who will respond to calls.

In many instances the osteopaths have seen the opportunity, and have flocked to various communities in numbers equaling more than half the doctors of medicine, and since the experience of the war, people are beginning to use them for general practice calls. Here is a fault that should be corrected. Doctors of medicine must not become difficult to secure if we are to retain the good will and the loyalty of the public.

The allure of the specialty has taken hold of the younger men. How many are asked even before graduation, "What specialty are you going into?" How many select their specialty and begin preparation for it as soon as their required intern year is finished? It has been our belief, although we know many teachers do not agree, that about three years in private general practice before the study of the specialty would add incalculable experience and resources in the form of general understanding. It would round out a man who expects to limit his practice and remind him that there is more than one organ in the human body. If the specialty boards would all require two or three years of private general practice, many a young doctor would stay in general practice where, perhaps, he should have stayed. Not all are equipped to become specialists, and maybe too many aspire. This requirement would help solve the problem of lack of general practitioners.

Dean Furstenberg of the University of Michigan Medical School has proposed a plan approved by the Executive Committee of the Council aimed to interest young medical graduates to practice in less populous regions of the state. In substance, the proposal suggests an affiliation with some of the smaller hospitals of the state for training of young men who will give two years to a general

residency. During this period they will spend six months in the Medical School and Hospital of the University of Michigan. Part of this time will be devoted to a review of the basic sciences, but these subjects will be taught from the standpoint of the clinician and in close correlation with clinical medicine. One half day will be spent in the basic science departments and the remainder of the day in clinical work at the hospital. Emphasis will be placed on the basic sciences, but the resident will not be divorced from the genuine practical work of the clinical departments during his six months' residence in Ann Arbor.

ANOTHER WAR?

SENATOR ARTHUR H. VANDENBERG, President of the Senate and Chairman of the Foreign Relations Committee of the Senate, in a speech to the Senate on April 16, 1947, told us that the appropriation of four hundred millions of dollars to Greece and Turkey might be the last chance to do anything to stop Communism, short of war. Our national personages have war in the back of their heads—they are thinking of that possibility.

And if war comes, what of the position of the medical profession? Are we also thinking of the possibility and our part in it? After the first world war we planned not as a profession, but as reserve officers, reserve organizations and veterans' organizations. We planned how best to serve, made skeleton organizations, and studied procedures. That had also been done long before the first world war. We had Medical Reserve officers beginning in 1910; the editor was one.

But those plans did not solve the difficulties encountered when war came. The first world war was medically officered by considerable effort, but in the second a degree of compulsion was used. Medical men were practically brow-beaten into the service. They were told here in Michigan that if under a certain age, they must apply for a commission before their essential status at home could even be considered. Many complied and then were stuck. The Council of the Michigan State Medical Society protested this procedure and offered suggestions—that the War Department determine how many and what officers they needed, commission and indoctrinate them, then send them home to their practice until a few weeks before they would be needed. It was believed that the War Department would be able to estimate the time of need sufficiently early to train these officers in their specific duties, and to have them ready and available when the time should come.

We did not agree that the need for the services would be one doctor for each 143 men in service in this country, even though that might be the need in combat areas. Events proved that such a plan might have worked. The need in combat areas was great and the service wonderful, but what a waste of material in the camps and home bases!

If we have another war, which God forbid, will we again strip the home front and allow our well-trained doctors to rusticate, while sitting and waiting and doing nothing helpful? Morale cannot keep up under such circumstances.

The Surgeon General of the Army asked some time ago that a committee of returned medical officers be appointed to advise with him in case of emergency. It was appointed. Has that committee ever been actuated?

We appreciate that war is waste, but that waste should be minimized wherever possible, and we can see no need to strip the civilian population of its medical servants to the point of actual scarcity in order to fill a table of organization. Such waste should never happen again. Our ideas may not be workable, but someone must have an idea that is feasible, and it cannot be considered unless it is proposed. After all, the Medical Corps must be made up of our members and they should be thinking of what presumably is going to happen. The policy for the next war can be developed by careful thinking before the necessity for hasty action.

INCOME TAXES UNFAIR?

IT IS ALLOWABLE for doctors attending medical society conventions to deduct from income for tax purposes traveling expenses, cost of hotel rooms, and meals. Until a couple of years ago these same expenses were deductible when the doctor took postgraduate training. Now these expenses are not deductible, under a ruling of the internal revenue department.

We can appreciate that the government wishes to collect every last dollar possible with the rising costs of government and its ever-increasing activities, but is this present ruling reasonable? Will it backfire, so to speak, and in the end prove a bad investment for the whole public?

Both of these activities of the doctor, attending medical conventions and attending postgraduate medical instruction, are done with one purpose in mind—improvement of the benefits to patients receiving treatment from the doctors. If the government penalizes doctors who attend postgraduate courses and instructions, necessarily some doctors at least will not be able to attend these courses, and the patients will be the losers.

The Executive Committee of the Council of the Michigan State Medical Society had this matter up for discussion in March and passed it along to the American Medical Association through our delegates. This is an important problem and must be actuated from the national level, but we wish our members to understand that efforts are being made to change a very unfortunate ruling of the Internal Revenue Department.

If expenses, dues, and travel, when attending medical society meetings are deductible for tax purposes, then there is no reason for not deducting the same expenses incurred when attending postgraduate training. Both services are intended to make the doctor a better doctor—or perhaps the government does not want our doctors to improve themselves. The government, in certain services, demands that the doctor who renders those services must be a diplomate of one of the American Specialty Boards. In this other department, however, the government does its utmost to make the securing of these diplomas next to impossible!

MORE PROPAGANDA?

"SO YOU CAN'T GET A DOCTOR?" Albert Q. Maisel has again broken into print in *Colliers* (May 17, 1947) with a page and a half picture of a waiting line at Bellevue Hospital, New York. No mention is made of the fact that there probably is always a waiting line in that and many other charity hospital clinics. The article calls attention to the shortage of physicians which "may jeopardize the health of everyone for many years to come." Maisel charges that this shortage exists because "the medical colleges and the American Medical Association have embarked on a cutback program which can only increase our deficit of physicians and result in needless suffering, ill health and, often, an all-too-early death for many Americans."

He mentions the plea of the American Medical Association, through its representative in testimony before the Senate Military Affairs Committee, May 1, 1945, asking for changes in the draft regulations so that we could have more premedical students ready for the postwar years of increased need for doctors. We predicted this shortage of doctors in two editorials—"Postwar Doctors, April, 1943, and "Future of Medicine," May, 1943, when the teen-agers were drafted, and were not allowed to enter premedical courses. In July, 1944, "Doctors for the Postwar Period," we reported how the military forces sent to college only limited numbers, deliberately to create a shortage of 3,110 students needed to maintain the numbers of doctors lost each year by death, retirement, and other reasons. The postwar period is here, and with it the shortages we predicted, which the American Medical Association begged to prevent. The University of Michigan does not have a graduating class in Medicine this year, for the reason that the students of the accelerated program have all finished, and there were no premedical students to take their place. The normal flow of premedical students had been interfered with by the refusal of Selective Service to allow exemptions for such young students, and demanding them in the military forces. When we protested, they told us we had no reason to worry for there would be thousands of doctors coming back from the services sufficient to fill all needs. The Government was wrong, as the profession told them, but now who is given the blame?

A ridiculous argument as to why there is a shortage is given, with the weight of apparent study and creditability. Maisel mentions the small numbers of physicians in thinly settled areas and smaller cities, and the "maldistribution" of doctors in general. A question was sent out to the fifteen largest cities of the country, asking: "Does your city have surplus physicians available for transfer elsewhere without substantial reduction of health standards?" If we had received such a message, as Bruce H. Douglas, M.D., Health Commissioner of Detroit, did, we would have answered "NO" without any qualification. And our reason? There may be a shortage in the City of Detroit and there may not. There are undoubtedly some doctors there who are not working to the limit of their strength as they did during the war, but the big question is "Who has the right to redistribute them?" Is that not a part of the inalienable American right to choose where to work? Or are we, because of our calling and special training,

robbed of that right and placed at the disposal of some social worker?

The article also takes the profession to task for its bent on "specialization." The field of medicine has become so extensive that no human mind can master it all; hence, the natural result of specialization. Maisel cited Detroit with "1992 'active physicians' including those in military service. But 613 of these are full-time specialists; 762 more are part-time specialists; only 637 are general practitioners—the kind of doctors most people must rely on most of the time." Is this a condition for which the profession should be held up to severe criticism? Is it not, instead, an evidence that the doctors of Detroit, and of Michigan, are bending every effort to meet the requirements of the public? Two thirds of them in Detroit have spent considerable time, often years in extra study to make themselves better doctors, and to be able to take care of more people. We know that same distribution of fields of practice holds in more than one other city in Michigan, and some even "worse" than Detroit. The great problem is to train general practictioners, and to induce some of our younger doctors to stay in that field, but that is not the prerogative of the social planners and the social writers. It is our own problem.

Is this article by Maisel another step in the apparently deliberate scheme to discredit medicine, and show up the profession in an unfavorable light with an ultimate aim to socialize the group?

GOOD PUBLIC RELATIONS

THE *Detroit Free Press,* on May 13, 1947, published a good editorial* of more than half a column calling attention to the good that has resulted from proper use of vivisection by medical investigators, as a result of which operations are now done to correct "blue babies." The picture was published of a mother and child who had happily celebrated Mother's Day because the medical profession had discovered how to make these babies well.

The *Free Press* editorially endorsed the plan of vivisection which makes such progress in medical and surgical science possible. We are gratified at the stand taken by this newspaper, and congratulate the editor for his unhesitating pronouncement.

In offering this testimonial, we cannot help but contrast the situation now after less than two years of well-directed public relations, and ask: Would such an editorial have appeared in such a paper five or twenty years ago?

Well done! We need more of the same publicity. Such a feeling of confidence a few years ago would have stimulated a much different type of national health schemes.

*See Page 628, *"A Mother and Her Baby and Science."*

ON THE RUN . . .

The potent remedies given us by the modern laboratory cannot be used as placebos.

• • •

Sulphonamide anuria is not due to mechanical obstruction but appears to be the result of a hypersensitivity reaction.

• • •

With chronological aging the basal metabolic rate tends to fall and the blood sugar level to rise.

• • •

It is believed unwise to employ tuberculin-negative nurses in sanatoria.

• • •

In man the main source of the antipernicious anemia principle is in the upper two-thirds of the stomach.

• • •

Negroes rarely suffer from angina, although they have as much coronary sclerosis as white people.

• • •

Only 1 per cent of the general population can be regarded as allergic to egg protein.

• • •

Early postoperative application of 5 to 10 per cent cocaine to the pharynx and pyriform sinuses is an effective preventive of atelectasis.

• • •

High oxygen concentrations in anesthesia tend towards production of atelectasis.

• • •

Strength is related to body size, but weight accounts for only 25 per cent of the variation in strength.

Selected by W. S. Reveno.

ATROPHIC RHINITIS

Patients suffering with moderate or even advanced atrophic rhinitis will be greatly relieved, and the nasal mucous membrane will actually again become moist, if they will wear a small loose piece of lamb's wool in the nostrils. We have advised that for years with success.

At the AMA Centennial in Atlantic City, 15,272 doctors of medicine registered—946 from Michigan.

Detroit Physiological Society

Session of April 17, 1947

Interaction Between Adjacent Nerve Fibers and the Pharmacology of Synaptic Transmission

Amedo S. Marrazzi, M.D., Department of Pharmacology and Therapeutics, Wayne University College of Medicine.

The electrical currents generated by a nerve fiber during its activity are shown to influence the excitability of neighboring fibers so that the action potential in response to a constant testing stimulus applied to a particular fiber will vary with the phase of the conditioning current to which a neighboring fiber exposes it. Thus, excitability of the conditioned fiber varies in a predictable fashion, determined by the current patterns characteristic of the traveling nerve impulses initiated by the testing and conditioning stimuli. The possible role of such phenomena in synaptic transmission must be considered.

Synaptic transmission is studied in sympathetic ganglia (cat) by recording the action potentials appearing in the postganglionic nerves in response to electrical stimulation of the preganglionic nerves. Drugs reach the ganglia through their intact circulation. Simultaneously *nerve conduction* is followed by recording the potentials in "through" fibers passing through the ganglia without synapsing. The humoral agents and drugs thus studied all affect synaptic transmission without altering nerve conduction, differentiating these two phenomena and indicating that the mechanisms involved are different. Adrenaline blocks synaptic transmission and fulfills the, hitherto, undescribed role of a humoral synaptic inhibitory agent opposed to and reciprocating with the ganglionic cholinergic excitatory mechanism. Atropine blocks, while acetylcholine, di-isopropylfluorophosphate (DFP) and physostigmine enhance synaptic transmission. Close arterial injection of DFP or physostigmine apparently builds up paralytic concentrations of acetylcholine since transmission is blocked. It seems probable that at ganglionic synapses lectrical and humoral transmission mechanisms co-exist, supplementing and complementing each other.

This study was aided by a grant from Parke, Davis and Company.

Current Vitamin C Nutritional Status Studies

O. N. Miller, M.A., Research Laboratory, Children's Fund of Michigan, Detroit.

Methods recently developed by Lowry and Bessey, in New York, permit determination of vitamins A and C, thiamine, riboflavin, serum protein and alkaline phosphatase in blood samples obtained from a finger puncture. These micromethods, and others which are being devised, for the first time provide a practical means of determining nutritional status quickly, by a small staff and without a prohibitive amount of equipment. We have determined vitamin C in fasting blood samples from 293 children two to eighteen years old by the Lowry and Bessey micro-technique based upon the Roe and Kuether method of analysis. Blood levels below 0.4 mg. per 100 ml. are usually considered indicative of unsatisfactory nutritional status with respect to vitamin C. In a group of thirty-two children, eleven had plasma levels of 0.4 mg. per 100 ml. or lower and only three had 1.2 mg. or more in the spring. In the fall, only seven children of the same group showed levels below 0.4 mg., and high levels were found for nine, confirming the seasonal variation in blood vitamin C levels. Of eighty-seven children from whom blood samples were taken at the start, in the middle, and at the end of a six-week camp period, twenty-six showed initial plasma levels below 0.4 mg. and only thirteen had 1.2 mg. or more per 100 ml. The final values were higher for all but seven children; only two had less than 0.4 mg., and sixty-five showed over 1.2 mg. per 100 ml. of blood. This improvement undoubtedly was the result of the more healthful environment and regimen at the camp.

The vitamin C intakes of two boys and two girls during seven consecutive days was determined by analysis and by calculation from food composition tables. The values obtained by analysis were only slightly lower than those calculated from the literature. For three of the four children, the average daily intakes of vitamin C were below the 75 mg. per day recommended by the Food and Nutrition Board of the National Research Council. Of the total vitamin C ingested by the children, analyses showed approxi-

mately two-thirds was reduced ascorbic acid and one-third was oxidized (dehydro-) ascorbic acid. The data indicate that children can utilize dehydroascorbic acid or are able to maintain good plasma ascorbic acid levels with good diets providing less than 75 mg. of vitamin C per day.

Histological and Physiological Properties of Nerves from the Knee Joint of the Cast.

Ernest Gardner, Department of Anatomy, Wayne University.

It has been shown that some myelinated fibers in an articular twig of the posterior tibial nerve are derived from Ruffini-type endings in the posterior part of the capsule, while others accompany blood vessels to other regions of the knee joint. In the initial study of functions of these fibers, three different methods were used.

1. The sciatic nerve was cut and all distal branches except the posterior tibial and its articular branch severed. When the sciatic was stimulated, no muscle contractions resulted. The spike recorded from the articular nerve following such stimulation was the compound potential of all A fibers in the nerve.

2. Spikes were recorded after stimulation of dorsal roots. The inflow thus determined was over lumbar 6 and 7, and sometimes sacral 1. Results indicated, therefore, that most if not all myelinated fibers in the articular nerve were afferent. The temporal dispersion allowed the recording of numerous elevations corresponding to fibers conducting at rates of 8 to 85 meters a second. This fits with the grouping of fiber sizes determined previously.

3. The articular branch was severed from the sciatic. Spontaneous potentials were usually present. Trains of spikes were recorded following pressure on the capsule. The receptors stimulated appeared to be slowly adapting and were probably the Ruffini-type endings described previously.

COMPULSORY SICKNESS TAX BILL

"The Hawaii Compulsory Sickness Tax bill failed to get out of Committee.

"Dr. Sinai did not come up from under cover until the last week of the Legislature. Then he addressed a meeting sponsored by a social workers group which, in spite of large advance publicity, attracted fewer than 200 people. Those who listened to Dr. Sinai were presented with a copy of *Blueprint for the Nationalization of Medicine* as they left the auditorium. Since then, nothing further has been heard from Dr. Sinai."—Letter from Dr. Lyle G. Phillips, Honolulu, Hawaii, May 6, 1947.

Pyelonephritis

By Joseph M. Erman, M.D.
Detroit, Michigan

Two cases of pyelonephritis with renal stone causing obstruction, stasis, infection, and abscess with symptoms of chills and fever, but pointing to localization elsewhere than the renal system, culminated at the Grace Hospital in nephrectomy.

Case 1.—Mrs. A. Z., aged forty-nine, had right-sided pain recurring with each menstral period for many years. So convinced was she that this was "female change" and that no treatment was necessary, that she called professional help only when the pain was excruciating. She said she had "change-of-life pain." But when asked about the character and location of the pain, she described classical right renal colic. Chills and fever were present.

She was admitted December 12, 1944. Pyelography was done on December 20. A staghorn calculus was revealed in the right kidney. Right nephrectomy was done December 23. Convalescence was rapid. Relief of pain was complete.

Nonprotein nitrogen, 28
Red blood cell count, 3,650,000; polymorphonuclears 89 (79, 10); lymphocytes 11
Temperature range: on admission, 101.8, 102 to 97.4; postoperative first day, 103 to 102.1; thereafter, 99 to 97.4
Pulse range: 96 to 64
Respiration range: 24 to 16

Case 2.—W. C., aged forty-four, was seized with severe abdominal pain about eight months prior to the illness for which he was hospitalized. Bloody frequent stools, chills and fever persisted for two weeks during which time he was kept in bed. Liver extract and vitamin B were given intramuscularly. After apparent recovery, only slight interference with work was caused by short and mild recurrences.

Suddenly, violent pain occurred in the left upper quadrant. There was absence of stool and gas for two days. He was brought to Grace Hospital on July 12, 1946. Penicillin was injected every three hours from July 16 to 26 in 20,000 unit doses. Barium enema and KUB were done. The colon was normal. A small calculus was seen in the region of the left ureter at its junction with the kidney pelvis. Retrograde pyeloraphy on July 19, 1946, revealed complete obstruction of the pelvis by this stone. The left kidney was removed on July 22, 1946.

Nonprotein nitrogen, 33
Red blood cell count, 4,140,000; polymorphonuclears 79 (68, 11); lymphocytes 20; eosinophils 1.
Temperature range: on admission, 103, 101.4 to 97.4; postoperative first day 101.4; thereafter, 100 to 96.
Pulse range: 98 to 70
Respiration range: 28 to 16

Pathological report: Acute exacerbation of a chronic pyelonephritis with multiple small abcesses of parenchyma and hemorrhage and ulceration of pelvis.

Michigan State Medical Society

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1867—*J. H. Jerome, Saginaw
1868—*Wm. H. DeCamp, Grand Rapids
1869—*Richard Inglis, Detroit
1870—*I. H. Bartholomew, Lansing
1871—*H. O. Hitchcock, Kalamazoo
1872—*Alonzo B. Palmer, Ann Arbor
1873—*E. W. Jenk, Detroit
1874—*R. C. Kedzie, Lansing
1875—*Wm. Brodie, Detroit
1876—*Abram Sager, Ann Arbor
1877—*Foster Pratt, Kalamazoo
1878—*Ed. Cox, Battle Creek
1879—*George K. Johnson, Grand Rapids
1880—*J. R. Thomas, Bay City
1881—*J. H. Jerome, Saginaw
1882—*Geo. W. Topping, DeWitt
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1890—*L. W. Bliss, Saginaw
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1892—*Charles J. Lundy (died before taking office)
*Gilbert V. Chamberlain, Flint, Acting President
1893—*Eugene Boise, Grand Rapids
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1897—*Joseph B. Griswold, Grand Rapids
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1899—*A. W. Alvord, Battle Creek
1900—*P. D. Patterson, Charlotte
1901—*Leartus Connor, Detroit
1902—*A. E. Bulson, Jackson

*Deceased.

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1915—*A. W. Hornbogen, Marquette
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1917—*Andrew P. Biddle, Detroit
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1934—*R. R. Smith, Grand Rapids
1935— Grover C. Penberthy, Detroit
1936— Henry E. Perry, Newberry
1937— Henry Cook, Flint
1938— Henry A. Luce, Detroit
1939— Burton R. Corbus, Grand Rapids
1940— Paul R. Urmston, Bay City
1941— Henry R. Carstens, Detroit
1942— H. H. Cummings, Ann Arbor
1943— C. R. Keyport, Grayling
1944— A. S. Brunk, Detroit
1945— R. S. Morrish, Flint

THE 82nd ANNUAL SESSION MICHIGAN STATE MEDICAL SOCIETY

E. F. Sladek, M.D.
Traverse City
Chairman, Council

Wm. A. Hyland, M.D.
Grand Rapids
President

John S. DeTar, M.D.
Milan
Speaker

L. Fernald Foster, M.D.
Bay City
Secretary

OFFICIAL CALL

The Michigan State Medical Society will convene in Annual Session in Grand Rapids, Michigan, on September 21, 22, 23, 24, 25, and 26, 1947. The provisions of the Constitution and By-Laws and the Official Program will govern the deliberations.

Wm. A. Hyland, M.D.
President

E. F. Sladek, M.D.
Council Chairman

J. S. DeTar, M.D.
Speaker

R. H. Baker, M.D.
Vice Speaker

Attest:
L. Fernald Foster, M.D.
Secretary

R. H. Baker, M.D.
Pontiac
Vice Speaker

Three-day Session of House of Delegates September 21-22-23, 1947

The 1947 House of Delegates of the Michigan State Medical Society will hold a three-day session beginning Sunday, September 21, at 2:00 p.m. The business of the House of Delegates will be transacted in the Ballroom of the Pantlind Hotel, Grand Rapids.

The House also will meet Monday, September 22, at 10:00 a.m. and at 8:00 p.m., and again on Tuesday, September 23, at 9:00 a.m., preceded by a breakfast for the Delegates at 8:00 a.m. The Tuesday deliberations are scheduled to be adjourned at noon, as the scientific assembly of the 82nd Annual Session convenes Tuesday at 1:40 p.m.

* * *

The intervals between meetings of the House of Delegates have been spaced to permit the Reference Committees ample time to transact all business referred to them.

Seating of Delegates

"Any Delegates-Elect not present to be seated at the hour of call of the First Session may be replaced by an accredited alternate next on the list as certified by the Secretary of the County Medical Society involved."

—MSMS By-Laws, Chapter 3, Section 3.

OUTLINE OF 1947 GENERAL ASSEMBLY SPEAKERS

82nd Annual Session, Michigan State Medical Society

Grand Rapids, September, 1947

	Tuesday September 23	Wednesday September 24	Thursday September 25	Friday September 26
A.M. 9:30- 9:50	The House of Delegates meets Tuesday Morning	Urology F. E. B. Foley, M.D. St. Paul, Minnesota	Medicine R. H. Williams, M.D. Boston, Mass.	Pediatrics C. A. Smith, M.D. Boston, Mass.
9:50-10:10		Medicine H. S. Gold, M.D. New York, New York	Ophthalmology C. S. O'Brien, M.D. Iowa City, Iowa	Pathology A. R. Moritz, M.D. Boston, Mass.
10:10-11:10		Intermission to View Exhibits	Intermission to View Exhibits	Intermission to View Exhibits
11:10-11:30		General Practice R. L. Cecil, M.D. New York, New York	Obstetrics F. E. Whiteacre, M.D. Memphis, Tenn.	Surgery W. W. Babcock, M.D. Philadelphia, Pa.
11:30-11:50		Surgery G. M. Curtis, M.D. Columbus, Ohio	Surgery Michael E. DeBakey, M.D. New Orleans, La.	Medicine W. E. Herrell, M.D. Rochester, Minn.
P.M. 12:00- 1:30	Two Section Meetings Dermatology Radiology	Four Section Meetings Urology Pediatrics Surgery Otolaryngology	Five Section Meetings Anesthesia Ophthalmology Medicine Gynecology-Obstetrics General Practice	One Section Meeting Pathology Discussion Conferences
1:40- 2:00	Surgery A. O. Whipple, M.D. N. Y., N. Y.	Gynecology A. D. Campbell, M.D. Montreal, Quebec	Syphilology P. A. O'Leary, M.D. Rochester, Minn.	END OF ANNUAL SESSION
2:00- 2:20	Medicine A. C. Ivy, M.D. Chicago, Ill.	Otolaryngology J. R. Lindsay, M.D. Chicago, Ill.	Pediatrics L. E. Holt, Jr., M.D. N. Y., N. Y.	
2:20- 2:40	Radiology W. C. Scott, M.D. St. Louis, Mo.	Pediatrics R. V. Platou, M.D. New Orleans, La.	General Practice R. L. Haden, M.D. Cleveland, Ohio	
2:45- 3:45	Intermission to View Exhibts	Intermission to View Exhibits	Intermission to View Exhibits	
3:45- 4:05	Dermatology Louis Schwartz, M.D. Washington, D.C.	Medicine R. A. Jensen, M.D. Minneapolis, Minn	Medicine J. D. Aronson, M.D. Philadelphia, Pa.	
4:05- 4:25	Obstetrics C. B. Lull, M.D. Philadelphia, Pa.	Surgery C. F. Dixon, M.D. Rochester, Minn.	Surgery S. W. Harrington, M.D. Rochester, Minn.	
4:30- 5:30	Discussion Conferences	Discussion Conferences	Discussion Conferences	
8:30	No Scientific Program	Officers Night and Biddle Oration	State Society Night	

Grand Rapids Will Be Host to MSMS in September

The Outline of the General Assembly for the 82nd Annual Session of the Michigan State Medical Society lists guest speakers from all parts of the United States and Canada. They are the usual stars in the medical world which always grace the annual conventions of the Michigan State Medical Society; they insure a valuable concentrated postgraduate course in all phases of medicine and surgery for Michigan's busy practitioners, on September 23, 24, 25 and 26, 1947.

Transportation.—The Pere Marquette Streamliners afford a convenient means of transportation to the MSMS Annual Session in Grand Rapids for hundreds of physicians in the central and southeastern part of the State. The General Assemblies have been so arranged in 1947 (from Tuesday noon to Friday noon) that doctors may arrive and depart conveniently on the Streamliners.

The Press Relations Committee for the 1947 MSMS Annual Session has been appointed by the General Chairman of the Arrangements Committee, Burton R. Corbus, M.D., Grand Rapids, as follows:

C. A. Payne, M.D., Grand Rapids, Chairman
G. T. Aitken, M.D., Grand Rapids
J. R. Brink, M.D., Grand Rapids

Special Societies Will Meet With MSMS

The Michigan Society of Anesthetists will meet in Grand Rapids on the occasion of the MSMS Annual Session. The annual dinner of the Society of Anesthetists will be held on Thursday, September 25, in Room 222 of the Pantlind Hotel, 6:30 p.m.

The Detroit Urological Society will convene on Tuesday, September 23, 1947, at Grand Rapids, during the MSMS Annual Session. The dinner meeting in Room 222 of the Pantlind Hotel will begin at 6:30 p.m.

The Michigan Pathological Society will also hold its meeting in conjunction with the MSMS Annual Session, in Grand Rapids on Friday, September 26, Room 222, Pantlind Hotel, beginning at 12:00 M. at which Allen Moritz, M.D., will speak. The meeting will continue through Friday afternoon and evening, and also Saturday morning, September 27.

The Medical Assistants Conference is scheduled for Wednesday, September 24, in the Schubert Room of the Pantlind Hotel, Grand Rapids, beginning at 3:00 p.m. The Medical Assistants group is composed of doctors' office secretaries. Prior to the war, their annual conference was a feature of the MSMS Annual Sessions. The afternoon meeting, featuring the following program, will end with a dinner at the Pantlind Hotel, 6:30 p.m.:

1. "Medical Economics and What the 'Lefts' are Thinking"— L. Fernald Foster, M.D., Bay City, Secretary, Michigan State Medical Society.
2. "What the Michigan Medical Profession is Doing—The Answer of the 'Rights' "—Jay C. Ketchum, Detroit, Executive Vice President, Michigan Medical Service.
3. "Health in a Package"— Hugh W. Brenneman, Lansing, Public Relations Counsel, Michigan State Medical Society.
4. "The Pacific was not so pacific"—(Illustrated by motion pictures) J. Duane Miller, M.D., Grand Rapids, Councilor Fifth District, Michigan State Medical Society.

Secretaries of all MSMS members are cordially invited to attend this informative Conference. No registration fee.

WHAT IT TAKES TO BE A DOCTOR OF MEDICINE

1. Four Years of High School
2. Two Years of College (including Physics, Chemistry, and Biology)
3. Four Years in a Medical College
4. One Year's Internship in a Hospital
5. A knowledge of the Human Body: Its Normal Structures, Functions and Governing Laws
6. A Knowledge of All Common Diseases in Order to Know What Disease is Present
7. A Knowledge of Effective Remedial Agents: Ability to Apply the One Most Needed.

These Minimum Essentials Should Be Possessed by All Who Treat the Sick

House of Delegates

ORDER OF BUSINESS*

SUNDAY, SEPTEMBER 21

Grand Ballroom, Pantlind Hotel, Grand Rapids

2:00 p.m. E.S.T.—First Meeting

1. Call to order by Speaker
2. Report of Committee on Credentials
3. Roll Call
4. (a) Appointment of Reference Committees:
   - (1) On Officers' Reports
   - (2) On Reports of The Council
   - (3) On Reports of Standing Committees
   - (4) On Reports of Special Committees
   - (5) On Amendments to Constitution and By-Laws
   - (6) On Resolutions

   (b) Appointment of Committee on Special Memberships and other Special Committees.
5. Speaker's Address—J. S. DeTar, M.D., Milan
6. President's Address—W. A. Hyland, M.D., Grand Rapids
7. President-Elect's Address—P. L. Ledwidge, M.D., Detroit
8. Annual Report of The Council—E. F. Sladek, M.D., Traverse City, Chairman
9. Report of Delegates to American Medical Association—L. G. Christian, M.D., Lansing, Chairman
10. Report of Commission on Health Care
11. Resolutions†
12. Reports of Standing Committees:
    - (a) Legislative Committee
    - (b) Committee on Distribution of Medical care
    - (c) Medical-legal Committee
    - (d) Preventive Medicine Committee
      - Cancer
      - Maternal Health
      - Venereal Disease Control
      - Tuberculosis Control
      - Industrial Health
      - Mental Hygiene
      - Child Welfare
      - Iodized Salt
      - Heart and Degenerative Diseases
    - (e) Committee on Postgraduate Medical Education
    - (f) Committee on Public Relations
    - (g) Committee on Ethics
13. Reports of Special Committees:
    - (a) Committee on Nurses' Training Schools
    - (b) Radio Committee (scientific)
    - (c) Advisory Committee to Woman's Auxiliary
    - (d) Scientific Work Committee (in Council's Report)
    - (e) Professional Liaison Committee
    - (f) Beaumont Memorial Committee
    - (g) Special Committee on Radio
    - (h) Postwar Education Committee
    - (i) Rheumatic Fever Control Committee
    - (j) Contact Committee with Association of Welfare Boards and Boards of Supervisors
    - (k) Committee on State Veterans Affairs
    - (l) Joint Committee on Infectious Diarrhea
    - (m) Special Committee on Uniform Fee Schedule for Governmental Agencies
    - (n) Committee on Rural Medical Service
    - (o) Committee on Courses in Medical Economics
    - (p) Committee on Michigan High School Athletic Accident Benefit Fund
    - (q) Committee on National Emergency Medical Service
    - (r) Special Committee to Meet With Congressman Engel
    - (s) Industrial Study Committee
    - (t) Special Committee on Revision of Constitution and By-Laws

MONDAY, SEPTEMBER 22

Grand Ballroom, Pantlind Hotel, Grand Rapids

10:00 a.m. E.S.T.—Second Meeting

14. Supplementary Report of Committee on Credentials
15. Roll Call
16. Unfinished Business
17. New Business*
18. Reports of Reference Committees:
    - (a) On Officers' Reports
    - (b) On Reports of The Council
    - (c) On Reports of Standing Committees
    - (d) On Reports of Special Committees
    - (e) On Amendments to Constitution and By-Laws
    - (f) On Resolutions

Recess

MONDAY, SEPTEMBER 22

Grand Ballroom, Pantlind Hotel, Grand Rapids

8:00 p.m. E.S.T.—Third Meeting

19. Supplementary Report of Committee on Credentials
20. Roll Call
21. Unfinished Business
22. New Business
23. Supplementary Reports of Reference Committees:
    - (a) On Officers' Reports
    - (b) On Reports of The Council
    - (c) On Reports of Standing Committees
    - (d) On Reports of Special Committees
    - (e) On Amendments to Constitution and By-Laws
    - (f) On Resolutions

Recess

*See the Constitution, Article IV, and the By-Laws, Chapter 3, on "House of Delegates."

†All Resolutions, special reports, and new business shall be presented in triplicate (By-Laws, Chapter 3, Section 7-n).

*All Resolutions, special reports, and new business shall be presented in triplicate (By-Laws, Chapter 3, Section 7-n).

TUESDAY, SEPTEMBER 23

Grand Ballroom, Pantlind Hotel, Grand Rapids

8:00 a.m. E.S.T.—Delegates Breakfast

9:00 a.m. E.S.T.—Fourth Meeting

24. Supplementary Report of Committee on Credentials

25. Roll Call

26. Unfinished Business

27. Supplementary Report of The Council

28. Supplementary Report of Reference Committees

29. Elections

(a) Councilors
7th District—T. E. DeGurse, M.D., Marine City—Incumbent
8th District—W. E. Barstow, M.D., St. Louis—Incumbent
9th District—E. F. Sladek, M.D., Traverse City—Incumbent
10th District—F. H. Drummond, M.D., Kawkawlin—Incumbent

(b) Delegates to American Medical Association
L. G. Christian, M.D., Lansing—Incumbent
F. E. Reeder, M.D., Flint—Incumbent

(c) Alternate Delegates to American Medical Association
H. H. Cummings, M.D., Ann Arbor—Incumbent
R. H. Pino, M.D., Detroit—Incumbent

(d) President-Elect

(e) Speaker of House of Delegates

(f) Vice-Speaker of House of Delegates

Adjournment

DELEGATES TO MSMS HOUSE OF DELEGATES, 1947

Names of Alternates appear in Italics

Officers
J. S. Detar, M.D.
Milan, Speaker
R. H. Baker, M.D.
Pontiac, Vice Speaker
L. Fernald Foster, M.D.
Bay City, Secretary
R. S. Morrish, M.D.
Flint, Immediate Past President

Allegan
O. D. Hudnutt, M.D., Plainwell
C. A. Dickinson, M.D., Wayland

Alpena—Alcona—Presque Isle
W. E. Nesbitt, M.D., Alpena
F. J. O'Donnell, M.D., Alpena

Barry
A. B. Gwinn, M.D., Hastings
C. A. E. Lund, M.D., Middleville

Bay—Arenac—Gladwin—Iosco
R. C. Perkins, M.D., Davidson Bldg., Bay City
W. S. Stinson, M.D., Allen Clinic, Bay City
C. A. Groomes, M.D., 405 N. Walnut, Bay City
G. M. Brown, M.D., 207 N. Walnut, Bay City

Berrien
D. W. Thorup, M. D., Benton Harbor
D. M. Richmond, M.D., St. Joseph

Branch
R. L. Wade, M.D., 116 E. Chicago, Coldwater
H. J. Meier, M.D., 87 W. Pearl, Coldwater

Calhoun
C. W. Brainard, M.D., 411 Central Tower, Battle Creek
B. G. Holtom, M.D., 815 Security National Bank, Battle Creek
G. W. Slagle, M.D., 1206 Security National Bank, Battle Creek
C. G. Wencke, M.D., 1015 Security National Bank, Battle Creek

Cass
S. L. Loupee, M.D., Dowagiac
J. H. Hickman, M.D., Dowagiac

Chippewa—Mackinac
B. T. Montgomery, M.D., Sault Ste. Marie
Clayton Willison, M.D., Sault Ste. Marie

Clinton
T. Y. Ho, M.D., St. Johns
P. R. Stoller, M.D., Fowler

Delta—Schoolcraft
A. H. Miller, M.D., Gladstone
W. A. Lemire, M.D., Escanaba

Dickinson—Iron
D. R. Smith, M. D., Iron Mountain
L. E. Irvine, M.D., Iron River

Eaton
G. C. Stucky, M.D., Eaton County Health Department, Charlotte
B. P. Brown, M.D., 116 Pearl St., Charlotte

Genesee
A. C. Pfeifer, M.D., Mt. Morris
J. E. Livesay, M.D., Mott Foundation Bldg., Flint
A. H. Kretchmar, M.D., 608 First National Bldg., Flint
A. N. Thompson, M.D., 1121 Union Industrial Bldg., Flint
V. H. Morrissey, M.D., 101 Stockdale Dr., Flint
F. W. Baske, M.D., Mott Foundation Bldg., Flint
G. E. Anthony, M.D., 1018 Detroit St., Flint
C. K. Stroup, M.D., 2002 E. Court St., Flint

Gogebic
W. L. Maccani, M.D., Ironwood
M. A. Gertz, M.D., Ironwood

Grand Traverse—Leelanau—Benzie
C. E. Lemen, M.D., 216 E. Front St., Traverse City
J. G. Zimmerman, M. D., State Bank Bldg., Traverse City

Gratiot—Isabella—Clare
M. G. Becker, M.D., Edmore
J. L. Rottschafer, M.D., Alma

Hillsdale
L. W. Day, M.D., Jonesville
O. G. McFarland, M.D., North Adams

Houghton—Baraga—Keweenaw
P. S. Sloan, M.D., Houghton
Alfred LaBine, M.D., Houghton

Huron
C. W. Oakes, M.D., Harbor Beach
W. B. Holdship, M.D., Ubly

Ingham
L. G. Christian, M.D., 108 E. St. Joseph, Lansing
H. W. Wiley, M.D., 300 W. Ottawa, Lansing
R. S. Breakey, M.D., 1211 Bank of Lansing Bldg., Lansing
F. L. Troost, M.D., Holt
J. M. Wellman, M.D., 301 Seymour, Lansing
Milton Shaw, M.D., 320 Townsend, Lansing
J. S. Rozan, M.D., 511 Bank of Lansing Bldg., Lansing
K. R. Hodges, M.D., 1116 Olds Tower, Lansing

Ionia—Montcalm
W. L. Bird, M.D., Greenville
M. M. Hansen, M.D., Greenville

Jackson
P. A. Riley, M.D., 500 S. Jackson, Jackson
C. S. Clarke, M.D., 605 Dwight Bldg., Jackson
C. R. Dengler, M.D., 305 Carter Bldg., Jackson
J. D. Van Schoick, M.D., Hanover

Kalamazoo
R. J. Armstrong, M.D., 605 Hanselman Bldg., Kalamazoo
L. W. Gerstner, M.D., 420 John St., Kalamazoo
W. A. Scott, M.D., 705 Hanselman Bldg., Kalamazoo
W. R. Kavanaugh, M.D., 1029½ W. North St., Kalamazoo

Kent
W. B. Mitchell, M.D., 510 Medical Arts Bldg., Grand Rapids
R. H. Denham, M.D., Metz Bldg., Grand Rapids
A. V. Wenger, M.D., 302 Loraine Bldg., Grand Rapids
L. E. Sevey, M.D., 400 Medical Arts Bldg., Grand Rapids
Harry Lieffers, M.D., 400-2 Medical Arts Bldg., Grand Rapids
Andrew VanSolkema, M.D., 953 Fulton E., Grand Rapids
Torrance Reed, M.D., Ashton Bldg., Grand Rapids
W. R. Torgerson, M.D., Metz Bldg., Grand Rapids
S. L. Moleski, M.D., 528 Medical Arts Bldg., Grand Rapids
C. E. Farber, M.D., 408 Metz Bldg., Grand Rapids
L. O. Grant, M.D., 420 Medical Arts Bldg., Grand Rapids
R. S. VanBree, M.D., 204 Loraine Bldg., Grand Rapids

Lapeer
D. J. O'Brien, M.D., Lapeer
H. M. Best, M.D., Lapeer

Lenawee
P. L. Miller, M.D., Adrian
A. S. Pasternacki, M.D., Adrian

Livingston
H. G. Huntington, M.D., Howell
H. L. Sigler, M.D., Howell

Luce
F. R. Koss, M.D., State Hospital, Newberry

Macomb
A. A. Thompson, M.D., 126 Cass Ave., Mt. Clemens
O. F. Banting, M.D., Richmond

Manistee
E. A. Oakes, M.D., Manistee
E. B. Miller, M.D., Manistee

Marquette—Alger
W. C. Lambert, M.D., 342 E. Ridge, Marquette
W. A. Corcoran, M.D., 700 Cleveland Ave., Ishpeming

Mason
R. A. Ostrander, M.D., Ludington
C. A. Paukstis, M.D., Ludington

Mecosta—Osceola—Lake
T. P. Treynor, M.D., Big Rapids
P. B. Kilmer, M.D., Reed City

Medical Society of North Central Counties
(Otsego—Montmorency—Crawford—Oscoda—Roscommon—Ogemaw)
R. C. Peckham, M.D., Gaylord
C. G. Clippert, M.D., Grayling

Menominee
W. S. Jones, M.D., Menominee

Midland
J. H. Sherk, M.D., Larkin Bldg., Midland
E. H. Meisel, M.D., 518 Lingle Lane, Midland
H. H. Gay, M.D., Dow Chemical Company, Midland

Monroe
T. A. McDonald, M.D., Monroe
J. P. Flanders, M.D., 120 Maples Blvd., Monroe

Muskegon
R. H. Holmes, M.D., 316 Hackley Union Bldg., Muskegon
T. J. Kane, M.D., 179 Strong Ave., Muskegon

Newaygo
J. W. O'Neill, M.D., White Cloud
T. R. Deur, M.D., Grant

Northern Michigan
(Antrim—Charlevoix—Emmet—Cheboygan)
John Rodger, M.D., Bellaire
B. T. Alm, M.D., Petoskey

Oakland
P. E. Sutton, M.D., 617 Washington Square Bldg., Royal Oak
H. A. Furlong, M.D., 207 Navajo Rd., Pontiac
A. H. Baker, M.D., 1110 Peoples Bank Bldg., Pontiac
C. T. Ekelund, M.D., Riker Bldg., Pontiac
T. H. Pauli, M.D., 206 Riker Bldg., Pontiac
F. J. Kemp, M.D., 1115 Peoples State Bank Bldg., Pontiac

Oceana
W. G. Robinson, M.D., Hart
M. G. Wood, M.D., Hart

Ontonagon
W. F. Strong, M.D., Ontonagon
H. B. Hogue, M.D., Ewen

Ottawa
D. C. Bloemendaal, M.D., Zeeland
K. N. Wells, M.D., Spring Lake

Saginaw
L. C. Harvie, M.D., 495 Weichmann Bldg., Saginaw
C. E. Toshach, M.D., Route No. 7, Saginaw
Herbert Kleekamp, M.D., 1005 Gratiot, Saginaw
Stuart Yntema, M.D., 333 S. Jefferson, Saginaw

Sanilac
R. K. Hart, M.D., Croswell
N. J. Ellis, M.D., Croswell

Shiawassee
C. L. Weston, M.D., Owosso
W. L. Merz, M.D., Owosso

St. Clair
George Waters, 9400 Military, Pt. Huron
W. H. Boughner, M.D., Algonac

St. Joseph
R. A. Springer, M.D., Centreville
R. J. Fortner, M.D., Three Rivers

Tuscola
L. L. Savage, M.D., Caro

Van Buren
W. R. Young, M.D., Lawton
J. F. Itzen, M.D., South Haven

Washtenaw
B. M. Harris, M.D., Ypsilanti
H. H. Riecker, M.D., St. Joseph Mercy Hospital, Ann Arbor
P. S. Barker, M.D., University Hospital, Ann Arbor
C. H. Ross, M.D., 715 University Avenue, Ann Arbor
R. W. Teed, M.D., 215 S. Main, Ann Arbor
R. I. Seime, M.D., Martha Washington Theater Bldg., Ypsilanti
H. A. Miller, M.D., 201 S. Saline, Ann Arbor
J. M. Sheldon, M.D., University Hospital, Ann Arbor

Wayne
R. L. Novy, M.D., 858 Fisher Bldg., Detroit
Douglas Donald, M.D., 7815 E. Jefferson Ave., Detroit
G. C. Penberthy, M.D., 1515 David Whitney Bldg., Detroit
C. S. Kennedy, M.D., 10 Peterboro Ave., Detroit
W. D. Barrett, M.D., 311 David Whitney Bldg., Detroit
T. K. Gruber, M.D., Wayne County General Hospital, Eloise
S. W. Insley, M.D., 1202 Maccabees Bldg., Detroit
William Bromme, M.D., 318 Professional Bldg., Detroit
E. D. Spalding, M.D., 320 Professional Bldg., Detroit
D. C. Beaver, M.D., Woman's Hospital, Detroit
Arch Walls, M.D., 12065 Wyoming Ave., Detroit
W. W. Babcock, M.D., 868 Fisher Bldg., Detroit
R. H. Pino, M.D., 209 David Whitney Bldg., Detroit
W. B. Harm, M.D., 5884 W. Vernor Highway, Detroit

J. J. Lightbody, M.D., 501 David Whitney Bldg., Detroit
C. I. Owen, M.D., Grace Hospital, Detroit
F. A. Weiser, M.D., 1502 David Whitney Bldg., Detroit
W. J. Cassidy, M.D., 1737 David Whitney Bldg., Detroit
E. A. Osius, M.D., 901 David Whitney Bldg., Detroit
M. A. Darling, M.D., 673 Fisher Bldg., Detroit
H. J. Kullman, M.D., Veterans Administration Hospital, Detroit
W. J. Stapleton, Jr., M.D., 641 David Whitney Bldg., Detroit
E. G. Krieg, M.D., 1842 David Whitney Bldg., Detroit
A. E. Catherwood, M.D., 1337 David Whitney Bldg., Detroit
B. H. Douglas, M.D., 3919 John R St., Detroit
H. F. Dibble, M.D., 1313 David Whitney Bldg., Detroit
L. J. Morand, M.D., 641 David Whitney Bldg., Detroit
W. F. Seeley, M.D., 1807 David Whitney Bldg., Detroit
L. J. Bailey, M.D., 501 Professional Bldg., Detroit
C. K. Hasley, M.D., 1429 David Whitney Bldg., Detroit
F. G. Buesser, M.D., 1515 David Whitney Bldg., Detroit
D. C. Somers, M.D., 7600 Fisher Bldg., Detroit
W. L. Brosius, M.D., Herman Kiefer Hospital, Detroit
J. A. Kasper, M.D., Herman Kiefer Hospital, Detroit
R. A. Johnson, M.D., 7815 E. Jefferson Ave, Detroit
Lawrence Pratt, M.D., 2206 David Broderick Tower, Detroit
H. B. Fenech, M.D., 10 Peterboro Ave., Detroit
C. E. Lemmon, M.D., 1337 David Whitney Bldg., Detroit
R. V. Walker, M.D., 1255 David Whitney Bldg., Detroit
L. J. Gariepy, M.D., 16401 Grand River Ave., Detroit
H. L. Morris, M.D., 1069 Fisher Bldg., Detroit
E. C. Texter, M.D., 7457 Gratiot Ave., Detroit
C. L. Candler, M.D., 2006 David Broderick Tower, Detroit
L. W. Hull, M.D., 1701 David Whitney Bldg., Detroit
J. E. Croushore, M.D., 573 Fisher Bldg., Detroit
E. H. Lauppe, M.D., 1650 David Whitney Bldg., Detroit
J. E. Webster, M.D., 840 David Whitney Bldg., Detroit
C. F. Brunk, M.D., 7815 E. Jefferson Ave., Detroit
C. S. Ratigan, M.D., 22276 Garrison, Dearborn
W. G. Reid, M.D., 974 Fisher Bldg., Detroit
J. K. Bell, M.D., 1654 National Bank Bldg., Detroit
R. H. Bookmyer, M.D., 17198 Oak Dr., Detroit
H. G. Clark, M.D., 634 Maccabees Bldg., Detroit
L. T. Henderson, M.D., 13038 East Jefferson Ave., Detroit
L. S. Fallis, M.D., Henry Ford Hospital, Detroit
D. I. Sugar, M.D., 17 Brady St., Detroit
E. J. Hammer, M.D., 16616 Mack Ave., Detroit
E. H. Fenton, M.D., 15125 Grand River Ave., Detroit
R. C. Connelly, M.D., 1645 David Whitney Bldg., Detroit
D. H. Kaump, M.D., Providence Hospital, Detroit
W. P. Chester, M.D., 5057 Woodward Ave., Detroit
C. E. Simpson, M.D., 1210 Kales Bldg., Detroit
G. C. Thosteson, M.D., 1138 David Whitney Bldg., Detroit
J. A. Witter, M.D., 344 Glendale Ave., Detroit
C. J. Barone, M.D., 51 Eason, Highland Park
L. B. Young, M.D., 857 Fisher Bldg., Detroit
A. E. Schiller, M.D., 2010 David Broderick Tower, Detroit
D. M. Davidow, M.D., 1055 Fisher Bldg., Detroit
W. A. Chipman, M.D., 14920 Grand River Ave., Detroit
V. N. Butler, M.D., 28 W. Adams Ave., Detroit
R. Q. DeTomasi, M.D., 4690 Audobon, Detroit
C. J. Jentgen, M.D., 2501 W. Grand Blvd., Detroit
T. G. Amos, M.D., 201 Curtis Bldg., Detroit
P. H. Noth, M.D., 221 McKinley, Detroit
W. J. Yott, M.D., 15744 Harper, Detroit
F. W. Dwyer, M.D., 7448 Linwood, Detroit
E. D. Rothman, M.D., 722 Maccabees Bldg., Detroit
E. D. King, M.D., 5455 West Vernor Hwy., Detroit
J. E. Cole, M.D., 2905 West Grand Blvd., Detroit
I. S. Schembeck, M.D., 1655 David Whitney Bldg., Detroit
J. G. Slevin, M.D., 1514 David Broderick Tower, Detroit
A. H. Bracken, M.D., 13102 West Warren Ave., Dearborn
Ralph Kernkamp, M.D., 1229 David Whitney Bldg., Detroit
L. J. Gravelle, M.D., 1101 David Whitney Bldg., Detroit
W. E. Abbot, M.D., 1129 David Whitney Bldg., Detroit

Wexford

L. E. Showalter, M.D., 115 S. Mitchell, Cadillac
C. E. Merritt, M.D., Manton

REFERENCE COMMITTEES, HOUSE OF DELEGATES, 1947

(All meetings of Reference Committees will be held in the Pantlind Hotel, Grand Rapids)

Credentials Committee

J. J. O'Meara, M.D., Chairman
L. J. Bailey, M.D. — D. C. Somers, M.D.
Harry Lieffers, M.D.

Officers Reports
Room 322

C. W. Oakes, M.D., Chairman
W. D. Barrett, M.D. — D. R. Smith, M.D.

Reports of the Council
Parlor A

W. B. Mitchell, M.D., Chairman
L. G. Christian, M.D. — P. E. Sutton, M.D.
John Rodger, M.D. — C. I. Owen, M.D.
A. H. Kretchmar, M.D. — J. J. Lightbody, M.D.

Reports of Standing Committees
Room 324

William Bromme, M.D., Chairman
R. H. Pino, M.D. — R. C. Peckham, M.D.
H. G. Huntington, M.D. — P. S. Sloan, M.D.
Arch Walls, M.D. — W. S. Jones, M.D.

Reports of Special Committees
Room 327

L. W. Gerstner, M.D., Chairamn
H. J. Kullman, M.D. — W. S. Stinson, M.D.
A. C. Pfeifer, M.D. — T. Y. Ho, M.D.
B. T. Montgomery, M.D. — J. H. Sherk, M.D.

Amendments to Constitution and By-Laws
Room 328

R. A. Johnson, M.D., Chairman
T. K. Gruber, M.D. — H. A. Furlong, M.D.
T. A. McDonald, M.D. — W. F. Strong, M.D.
A. A. Thompson, M.D. — R. A. Springer, M.D.

Resolutions
Parlor B

R. S. Breakey, M.D., Chairman
E. G. Kreig, M.D. — H. H. Riecker, M.D.
G. C. Stucky, M.D. — E. A. Oakes, M.D.
C. L. Weston, M.D. — W. L. Maccani, M.D.

Special Memberships
Room 327

W. B. Harm, M.D., Chairman
B. H. Douglas M.D. — T. P. Treynor, M.D.
D. W. Thorup, M.D. — C. S. Clarke, M.D.

Press Relations Committee
Ballroom Checkroom

H. F. Dibble, M.D., Chairman
L. F. Foster, M.D. — J. S. DeTar, M.D.

MSMS STENOGRAPHERS' ROOM
Red Room off Ballroom of Pantlind Hotel

Michigan's Department of Health

Wm. De Kleine, M.D., Commissioner, Lansing, Michigan

CANCER REPORTABLE

At a meeting of the State Council of Health on April 24, 1947, the following regulation was approved:

Regulation to Require the Reporting of Cancer

On and after May 1, 1947, every physician, hospital superintendent and clinic director who has knowledge of a case of cancer shall, within ten days, report the same to the Michigan Department of Health on a form provided by said department. The report shall contain the name and address of the patient and either the name and address of the physician, or of the hospital superintendent and hospital, or of the clinic director and clinic, and such other data as may be required.

All such reports and records of the Michigan Department of Health pertaining to cancer are hereby declared to be confidential.

While the effective date is May 1, 1947, it will be several weeks before the form mentioned in the regulation will be available. As soon as the proper forms are printed they will be forwarded to the physicians of Michigan.

MANY LANDS STUDY HEALTH DEPARTMENT

From the far reaches of the world and representing a large share of its varied populations, scores of public health personnel of many nations have come to the Michigan Department of Health and its laboratories since the war years, to study its operation and function.

In the western hemisphere, they came from the provinces of British Columbia, Saskatchewan, Ontario and Quebec. From the south, they came from Mexico, El Salvatore, the Honduras and the extent of South America, Colombia to Cape Horn, including Ecuador, Peru, Brazil, Bolivia, Uruguay and the Argentine.

They came from the West Indies of Jamaica, Puerto Rico, the Dominican Republic, the Virgin Islands and jungle-inlaid Trinidad.

They came from Ireland on the Atlantic, Holland on the English Channel, Norway and Denmark on the cold Baltic and North Seas, from historic Greece in the Mediterranean and from the new Free France.

They came from templed India, war-torn China, divided Korea, and the newly independent myriad Philippines.

Their trips were arranged by the United States Public Health Service, the Institute of Inter-American Affairs, the International Health Division, the Rockefeller Foundation, UNRRA, the China Medical Board, Michigan School of Public Health, University of Michigan, Michigan State College, the Kellogg Foundation, the Commonwealth Fund, and the American Red Cross.

And their purposes were served. They were aided in finding information they sought to take back and adapt to the public health programs of their peoples.

SET VACCINE RECORD

During the two weeks which followed the smallpox outbreak in New York, the Michigan Department of Health Laboratories tested, filled and packaged 179,600 tubes of smallpox vaccine, more than half the usual annual output. Of this, 20,000 tubes were used to fill an emergency request from the Nassau county, New York, Health Department. In making the record emergency production, the staff of the laboratories worked days, nights and week ends.

NEED DISEASE REPORTS

"No health department, state or local, can effectively prevent or control disease without knowledge of when, where and under what conditions cases are occurring," according to *Public Health Reports,* March 28, 1946, by U. S. Public Health Service.

The department concurs and asks the assistance of every physician in reporting incidence of disease so that totals and areas affected can be known.

PREPARE FOR POLIO

The National Foundation of Infantile Paralysis, Inc., scheduled a one-day preparedness meeting held in Hotel Olds, Lansing, May 14. National authorities on poliomyelitis were presented. Special consideration was given to what should be done in the event of a poliomyelitis epidemic in this state.

POLLEN SURVEY

The Michigan Department of Health will conduct its annual Pollen Survey this year, if funds are made available by the legislature.

CONTINUING EDUCATION FOR DENTISTS

A three weeks' program of continuing education for dentists is now under way in the state. Nine authorities on phases of dentistry are appearing on the program. Each district dental society will have a one-day course with three speakers.

REFRESHER COURSE IN VD TREATMENT

A refresher course in the control of venereal disease was given all health officers of the state at the Michigan Rapid Treatment Center, Ann Arbor, May 8. It was the first such course in the state.

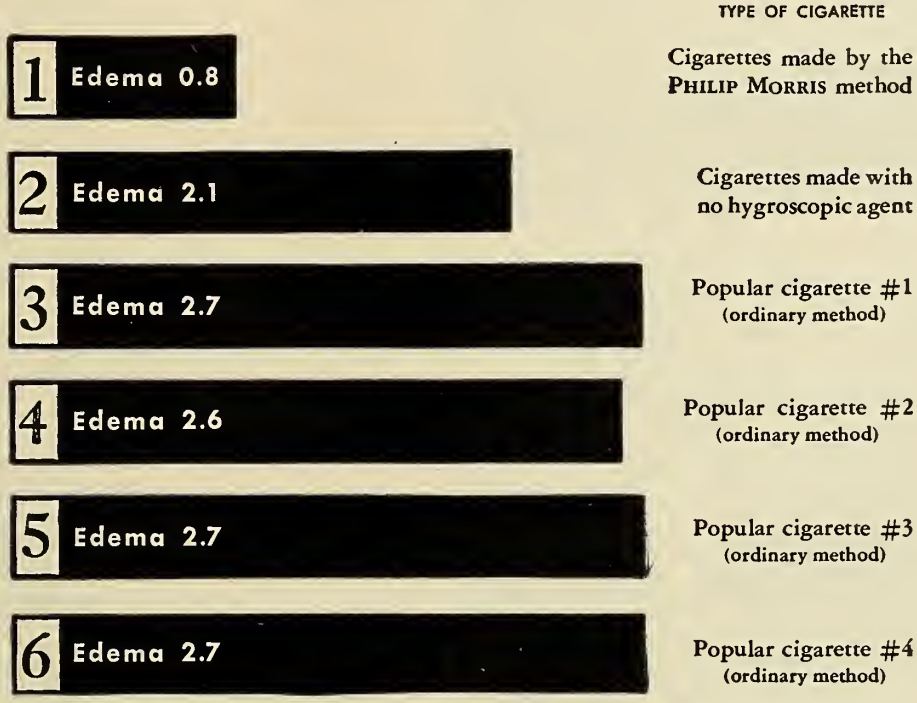
RABIES INCREASES

One hundred and twenty-four new cases of rabies have been reported in 13 southern Michigan counties so far this year. The number practically doubled in the past month. Five counties are quarantined: Berrien, Cass, Kalamazoo, Monroe and Van Buren. Cases are also reported in Genesee, Jackson, Lenawee, Shiawassee, Allegan, St. Joseph, Muskegon and Wayne. It

(Continued on Page 702)

How irritation varies from *different* cigarettes

Tests made on rabbits' eyes reveal the influence of hygroscopic agents*



CONCLUSION:* Results show that regardless of blend of tobacco, flavoring materials, or method of manufacture, the irritation produced by all ordinary cigarettes is substantially the same, and measurably greater than that caused by PHILIP MORRIS.

CLINICAL CONFIRMATION:** When *smokers* changed to PHILIP MORRIS, substantially every case of irritation of the nose and throat due to smoking cleared completely or definitely improved.

**N. Y. State Journ. Med. 35 No. 11,590 **Laryngoscope 1935, XLV, No. 2, 149-154*

TO THE PHYSICIAN WHO SMOKES A PIPE: We suggest an unusually fine new blend—COUNTRY DOCTOR PIPE MIXTURE. Made by the same process as used in the manufacture of Philip Morris Cigarettes.

Detroit Medical Hospital

7850 East Jefferson Avenue

A private hospital devoted to the diagnosis and treatment of mental and nervous illness, alcoholics and drug addicts. All accepted psychiatric and mental therapies.

Beautiful grounds facing the Detroit River

Registered by the American Medical Association

Licensed by the Michigan State Hospital Commission

DETROIT MEDICAL HOSPITAL

FITZROY 7100

7850 E. JEFFERSON AVE.

DETROIT 14 MICHIGAN

(Continued from Page 698)

is considered possible that the fox and skunk populations of the state may be infected, although no positive heads of either species have been forwarded to the Department of Health. All positive heads have been dogs' except those of a cow and a horse.

TB SURVEY RESULTS

Forty-one of the 1,992 Michigan state officials and employes x-rayed by the Michigan Department of Health in this year's tuberculosis case-finding program had some type of chest abnormality reflected in the first x-ray. Of these 11 are believed to have inactive tuberculosis, and only five are believed to have active tuberculosis. Sanatorium care has already been recommended for two of these.

FLY-FREE FAIRS

Michigan can have fly-free fairs this year, according to the Bureau of Engineering which is offering instructions for the use of DDT in barns, exhibition buildings, food counters and concession stands.

MOTHERHOOD SAFER

It gets safer every year to have a baby in Michigan. Deaths due to childbirth have continually decreased during the past ten years. In 1936, a total of 425 mothers died of childbirth causes; while in 1946 only 163 died of such causes. The death rate was 8.37 per hundred thousand population in 1936, and less than 3 per hundred thousand in 1946.

BIRTHS HIGH

Births in Michigan during the first quarter of this year exceeded deaths during the same period by 24,249. Births, numbering 38,835 during the quarter, exceeded those for any other first quarter recorded in the state. The five-year average for the quarter is 29,219.

MORE WHOOPING COUGH

Through press and radio, the Department is urging parents to have their children immunized against whooping cough. A total of 260 new cases appeared in the state the week ending May 2. They are in 17 counties.

WATER SUPPLIES TO BE POSTED

"Safe for Drinking" signs will again appear along Michigan's highways this year. The signs, which have not been available since before the war, are used to indicate all safe drinking supplies along roadways and in parks.

CLEAN-UP SAVES ACCIDENTS

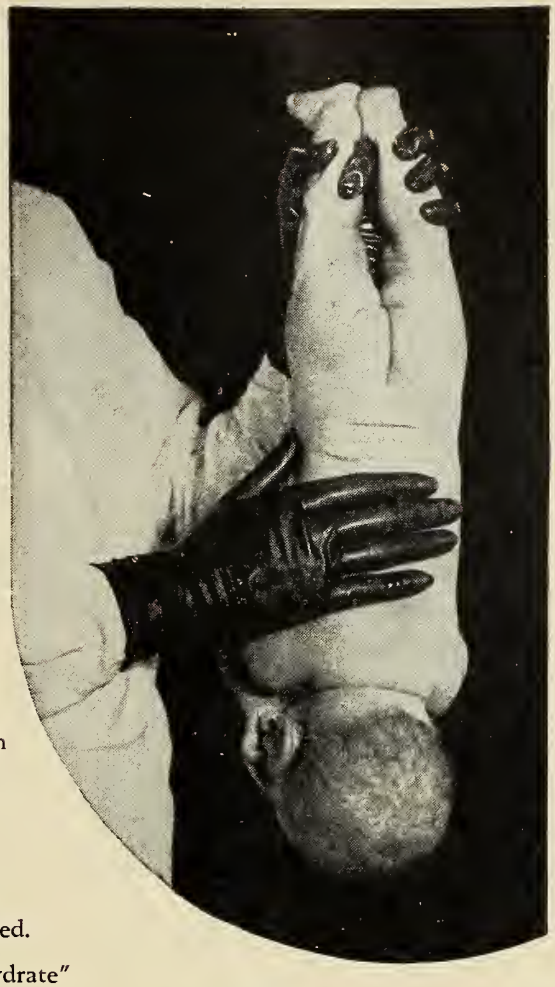
Housecleaning and clean-up days this year are being used by the Department to call attention to the large number of preventable accidents which occur in the home. Home accidents took 1,385 lives in the state last year. Of these, 751 were the result of falls; 252, of fires and explosions; 109, of suffocation; 38, of firearms; 35, of poison; and 34, of poison gas. Of the deaths due to

(Continued on Page 704)

Say you saw it in the Journal of the Michigan State Medical Society

Life expectancy

30 days?



Infant mortality during the first 30 days of life is on the *increase.* While the total infant mortality has been declining, the proportion of those who died within the first month *has actually increased* from 52.7% to 62.1%*. During this fatal first month the infant should be given every possible benefit. One step in the right direction is good feeding. In this way the gastro-intestinal hazards of excessive fermentation, upset digestion and diarrhea may be minimized.

'Dexin' has proved an excellent "first carbohydrate" because of its high dextrin content. It (1) resists fermentation by the usual intestinal organisms; (2) tends to hold gas formation, distention and diarrhea to a minimum, and (3) promotes the formation of soft, flocculent, easily digested curds.

Simply prepared in hot or cold milk, 'Dexin' brand High Dextrin Carbohydrate provides well-taken and well-retained nourishment. 'Dexin' *does* make a difference.

*Vital Statistics—Special Reports: Vol. 25, No. 12, National Office of Vital Statistics, Washington, D. C. (Oct. 15) 1946, p. 206.

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(Continued from Page 702)

falls, 669 were deaths of people over 65 years of age. Home accidents actually took almost as many lives as motor vehicle accidents in the state.

INCIDENCE OF COMMUNICABLE DISEASE

Disease	*April, 1947*	*April, 1946*	*7-year Median*
Diphtheria	22	26	22
Gonorrhea	834	1,022	683
Lobar pneumonia	108	67	235
Measles	343	9,794	3,737
Meningococcic meningitis	20	23	23
Pertussis	746	435	736
Poliomyelitis	5	2	1
Scarlet fever	511	782	1,090
Syphilis	1,236	1,558	1,235
Tuberculosis	481	412	507
Typhoid fever	3	9	6
Undulant fever	25	15	9
Smallpox	0	1	2

DEATHS INCREASE

Deaths in Michigan for the first quarter of 1947 exceeded last year's figures for the quarter and the five-year average. First quarter deaths for 1947 were 14,586, and for 1946 were 14,179. The five-year average was 14,425.

PERSONAL ITEMS

Russell E. Pleune, M.D., Director of the Northern Peninsula Office of the Michigan Department of Health has resigned to accept a position as Chief of the Tuberculosis Section of McCloskey Veterans' Hospital, Temple, Texas.

Doctor Pleune came to the Michigan Department of Health in December, 1945, following military service. He had been with the Bureau of Disease Control, Michigan Department of Health, from 1936 to 1938. From 1938 to 1942 he served as director of the Houghton-Baraga-Keweenaw Health Department in the Northern Peninsula.

Orla E. McGuire, District Engineer, was named Acting Director of the Northern Peninsula Office. Edna McInerney, M.D., was appointed acting Director of the Delta County Health Department for the period May 10 to July 1, replacing Dr. Pleune there.

* * *

Three members of the Bureau of Tuberculosis Control have resigned to enter chosen fields of service.

George S. Sherman, M.D., who has been Director of the Bureau since it was established in 1941 has entered the practice of internal medicine in Lansing.

William C. Winton, M.D., Assistant Director since May, 1945, leaves May 15 to become a member of the staff of the Eastern North Carolina Sanatorium, Wilson, North Carolina.

Edmund R. Clarke, M.D., tuberculosis physician, who came to the Department from the U. S. Public Health

(Continued on Page 724)

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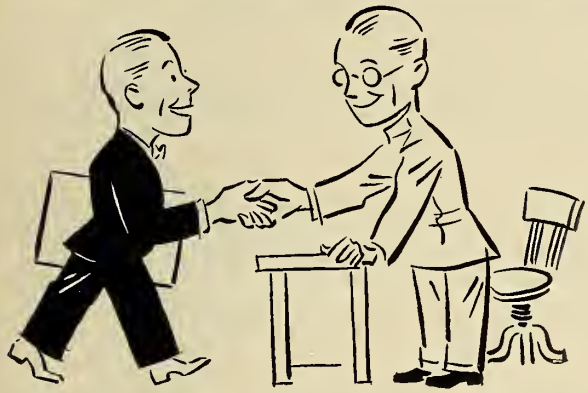

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In Memoriam

Wilford D. Albert, M.D., Leslie, was born in 1908. Graduated from the College of Medical Evangelists at Los Angeles. Practiced in Leslie for the past ten years. Doctor Albert died on March 10, 1947.

* * *

John L. Asselin, M.D., Detroit, was born in Windsor, Ontario, in 1880. He was graduated from the Detroit Medical College in 1905 and practiced the entire time in Detroit. Doctor Asselin died in Detroit on February 24, 1947.

* * *

Gilbert S. Field, M.D., Detroit. He was graduated from the Detroit College of Medicine and from St. Bartholomew's College, London. He had practiced in Detroit since 1891, and was a member emeritus of the Michigan State Medical Society since 1941. Doctor Field died in Detroit on April 5, 1947.

* * *

John H. Gordon, M.D., Birmingham, was born in 1891 in Anniston, Alabama. He was graduated from Tufts University Medical School in Boston in 1923. He is a veteran of World War 1. Doctor Gordon practiced in Birmingham for twenty-four years before his sudden death in Winter Haven, Florida, on March 3, 1947.

* * *

Joseph Johns, M.D., Ionia, was born at Van, Armenia, May 10, 1882, coming to the United States in 1906. He was graduated from the University of Illinois Medical School in 1911 and established his practice in Ionia directly, which he maintained until his death on April 6, 1947.

* * *

A. Dale Kirk, M.D., Flint, was born at Akron, Michigan, June 6, 1900. He was graduated from the University of Michigan Medical School. He was chief of staff at Hurley Hospital from 1944 to 1946 and chief of the department of obstetrics and gynecology. Doctor Kirk died in Flint on March 4, 1947.

* * *

John J. McDermott, M.D., St. Joseph, was born in Portland, Michigan, in 1887 and graduated from the University of Michigan Medical School in 1914. He served in the Army Medical Corps as a Captain in World War I. Following his discharge, he located in St. Joseph where he remained until his sudden death on March 19, 1947.

* * *

A. A. Rosenberry, M.D., Benton Harbor, was born in Peshtigo, Wisconsin, in 1884, the son of a physician. He was graduated from the University of Michigan Medical School, and, following internship, established his practice in Benton Harbor. Doctor Rosenberry died in Benton Harbor on February 18, 1947.

(Continued on Page 708)

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(Continued from Page 706)

Frank A. Tinker, M.D., Lapeer, was born in Conneaut, Ohio, April 20, 1859, and was graduated from the University of Michigan School of Medicine in 1884. He established his medical practice shortly thereafter in Lapeer where he remained until his death. Doctor Tinker was made a member emeritus of the Michigan State Medical Society in 1934. He died in Lapeer on April 8, 1947.

* * *

Morley S. Vaughn, M.D., Carleton, was born at Mt. Pleasant, Michigan, August 12, 1886 and was graduated from the Detroit College of Medicine and Surgery in 1912. He served as chief physician and surgeon at State Prison of Southern Michigan for four years, and as chief surgeon for the Detroit United Railway for six years. He practiced in Jackson, Maybee, and for the past several years in Carleton. Doctor Vaughn died in Monroe, March 15, 1947.

* * *

Burt D. Walker, M.D., Kalamazoo, was born in Kalamazoo on September 21, 1872, and was graduated from the University of Michigan Medical School in 1894. He practiced for nine years in New York City and since 1906 in Kalamazoo. Doctor Walker was elected to Life Membership in the Michigan State Medical Society in 1946. He died in Kalamazoo on March 10, 1947.

* * *

Thomas C. Weston, M.D., Muir, was born in Brownsville, Ontario, December 10, 1864, was graduated from the Detroit College of Medicine in 1893. He practiced medicine in Muir for fifty-five years. Doctor Weston died in Ionia on March 15, 1947.

* * *

J. R. Wiggers, M.D., Grand Rapids, was born in Drenthe and was graduated from Ohio State University Medical School in 1916. He practiced in Chicago and Ohio City, Ohio, before locating in Grand Rapids twenty years ago. Doctor Wiggers died suddenly in Grand Rapids on March 22, 1947.

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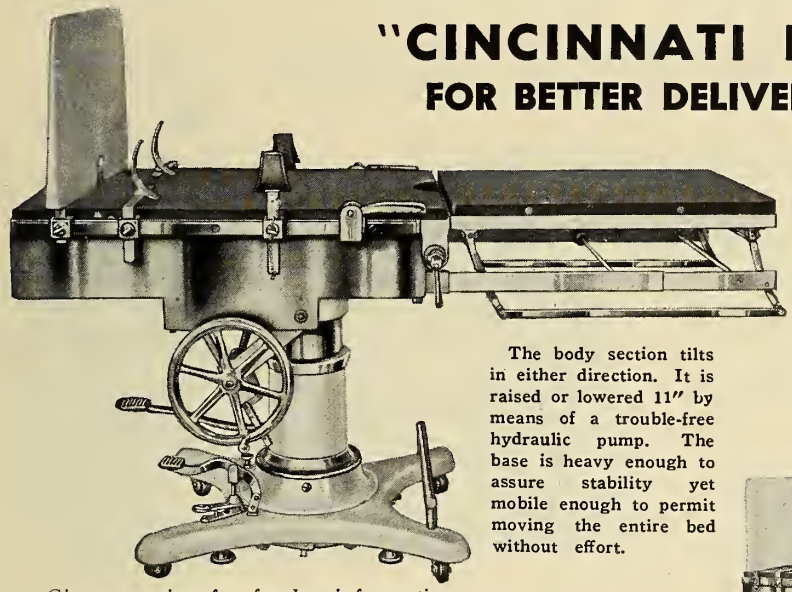

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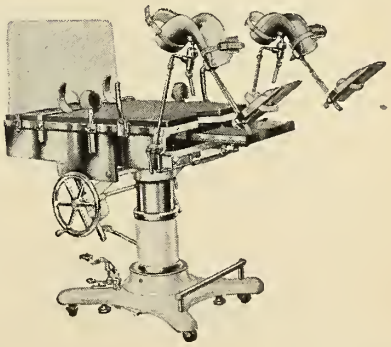

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What's What

Jerome W. Conn, M.D., of Ann Arbor is the author of an original article "Spontaneous Hypoglycemia" which appeared in JAMA of May 10.

* * *

Wm. S. Reveno, M.D., Detroit, is the author of an original article "Propylthiouracil in Thyroid Toxicosis" which appeared in JAMA of April 19.

* * *

James Clark Moloney, M.D., Detroit, is the author of an article on "The Cornelian Corner" which appeared in *The Psychiatric Quarterly* of October, 1946.

* * *

The American Congress of Physical Medicine will hold its 25th Annual Session at Hotel Radisson, Minneapolis, September 2-6, 1947. For Program write the Congress, 30 N. Michigan Avenue, Chicago 2, Illinois.

* * *

Commemorative Stamp.—The postoffice department has issued a new 3-cent stamp commemorating the 100th anniversary of the founding of the American Medical Association. The stamp went on sale June 9, 1947.

* * *

Alex S. and Sidney Friedlaender, M.D., Detroit, are the authors of an original article "Pyribenzamine in Hay Fever and Other Allergic Disorders" which appeared in the *Journal of Laboratory and Clinical Medicine,* December, 1946, number.

* * *

Special prescription pads for veterans' needs and including the formal authorization under the Veterans Administration are available, without cost, by writing the Michigan State Pharmaceutical Association, 1510 Olds Tower, Lansing 8, Michigan.

* * *

"In the November 1948 election, the people may be given a chance to remove ear-marked funds (including the Sales Tax Diversion amendment) from the Constitution and give complete control of state finances back to the Legislature . . ."—Michigan Survey of April 28.

* * *

L. J. Gariepy, M.D., Detroit, spoke on "Carcinoma of the Gall Bladder" at the annual meeting of the New Jersey Chapter, International College of Surgeons, held in Newark, N. J., May 7. He also addressed the Nebraska Chapter on May 22, in Lincoln, Nebraska.

* * *

LeMoyne Snyder, M.D., Lansing, will address the joint meeting of the Maine Medical Association and

(Continued on Page 712)

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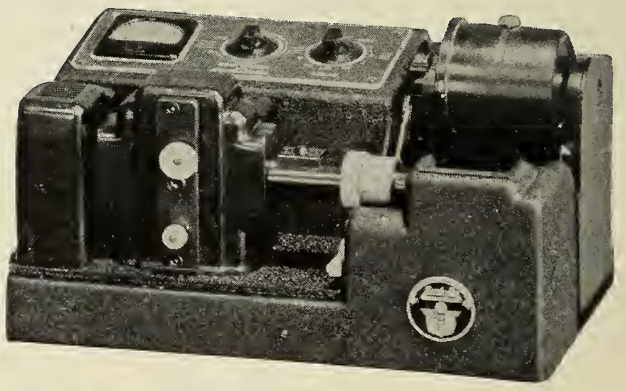

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(Continued from Page 710)

the Maine Medical-Legal Society in York Harbor, Maine, on June 24. His subject will be "Homicide Investigation and Medicine."

* * *

"Folvite," a new motion picture on folic acid in the treatment of anemia is available to county and special medical societies, without charge (16 mm., time, 20 minutes). Address Film Library of Lederle Laboratories, 30 Rockefeller Plaza, New York 20.

* * *

"The Trend Toward Labor Health and Welfare Programs" by Frank G. Dickinson, Ph.D., Chicago, as presented before the Annual County Secretaries and Public Relations Conference of the Michigan State Medical Society in Detroit on February 2, is abstracted in JAMA of April 26, Page 1285.

* * *

Wm. A. Hyland, M.D., Grand Rapids, President of the Michigan State Medical Society, has been appointed a member of the Committee on Practical Nursing of the Michigan Council on Community Nursing. The purpose of the Committee is to make more and better practical nursing available in Michigan.

* * *

"Senator Ferguson read the Bates Resolution calling for an end to federal aid for states in the United States Senate, saying: "We should think and think and think about the proposition of granting funds to states which don't necessarily need aid but must keep up with the Joneses."—*Survey Digest,* May, 1947.

* * *

The Detroit Society for the Prevention of Blindness was founded August 12, 1946, by the Lions Clubs of Metropolitan Detroit, and is associated with the National Society for the Prevention of Blindness of New York City. The Detroit headquarters is located at 1006 Michigan Bank Bldg. Judge Ned H. Smith is Chairman.

* * *

J. S. DeTar, M.D., Speaker of the House of Delegates, Michigan State Medical Society, spoke at the Secretaries Conference of the Indiana State Medical Association, at Indianapolis on January 12, 1947. The subject was, "Public Relations," and the paper appears in full in *The Journal of the Indiana State Medical Association* for May, 1947.

* * *

Professional Management, Battle Creek, announces the opening of a Detroit office at 428 Michigan Building, under the direction of Nelson J. Young as Resident Manager, with William N. Jones, Jr., as associate.

In addition to the new Detroit branch, PM has offices in Battle Creek, Saginaw, Grand Rapids, and affiliated offices in other cities.

* * *

M. H. Miller, M.D., of Detroit has an article in the May 3, 1947, number of the *Journal of the American Medical Association* on "General Practice in a Large Hospital" which is very instructive and outlines an Educational Program. This article was mentioned in his

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secretary's letter of May 12, with the admonition to read the article. Congratulations, Doctor Miller.

* * *

John J. McCann, M.D., Dean of Ionia's physicians delivered the third generation baby in one family recently. He ushered into the world a son born to Mr. and Mrs. Jedson Montgomery of Ionia; Mrs. Montgomery was aided by Dr. McCann at her birth nineteen years before; the doctor also was present when the youngster's grandmother was born thirty-nine years ago.

* * *

The Detroit Oto-Laryngological Society and the Southern Michigan Triological Society held a joint meeting in Ann Arbor, Saturday, April 26, 1947, with dinner at the Allenel Hotel, and scientific program at the University Hospital. Several members of the Oto-Laryngological staff presented papers on Acoustic Tumors, Congenital Atresia of the Middle Ear, and Carcinoma of the Larynx.

* * *

Surgery, Gynecology and Obstetrics for April 15, 1947, contains several papers by Michigan doctors: "Penicillin in Experimental Instestinal Obstructions; a Summary of Observations with Reference to Their Clinical Application," by Alexander Blain, III, M.D., Ann Arbor; "Osteomyelitis Following Compound Fractures," by Grover C. Penberthy, M.D., F.A.C.S., Detroit, and "Consideration of Hearing Impairment in the Treatment of Chronic Suppurative Otitis Media," by J. H. Maxwell, M.D., F.A.C.S., Ann Arbor.

The Central Association of Obstetricians and Gynecologists offers two $100 prize awards to physicians in the Central States for papers covering (a) the best investigative work and (b) the best clinical work in the fields of obstetrics and/or gynecology. Papers must be in the hands of Secretary John I. Brewer, M.D., 104 S. Michigan Avenue, Chicago, Illinois, no later than August 15, 1947.

* * *

The Third American Congress on Obstetrics and Gynecology will be held in St. Louis, September 8-12, 1947. Fred L. Adair, M.D., Chicago, is General Chairman; A. M. Campbell, M.D., Grand Rapids, is Membership Chairman for Michigan; Jean P. Pratt, M.D., of Detroit, is Chairman of the Scientific Exhibits Committee. Copy of the program may be obtained by writing Dr. F. L. Adair, 5848 Drexel Avenue, Chicago, Illinois.

* * *

Implementation of Federal Hospital Survey and Construction program in Michigan.—Governor Sigler has designated the State Administrative Board to act as a temporary agency to carry on the survey and planning program, under the Hill-Burton Act. In turn, the Administrative Board referred the detail work in connection with surveys and planning of hospitals of Michigan to its Building Committee composed of Fred M. Alger, Jr., Secretary of State, D. Hale Brake, State Treasurer, Eugene B. Elliott, Superintendent of Public Instruction, Eugene C. Keyes, M.D., Lt. Governor, Adrian M. Languis, State Engineering and Building Division.

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The Conference on Co-operation of Physicians in the High School and Physical Education Program, arranged by the American Medical Association, and scheduled for Highland Park, Illinois, October 16-18, 1947, will have a representative of the Michigan State Medical Society in the person of L. Fernald Foster, M.D., Bay City, MSMS Secretary.

Dr. Foster addressed the Au Gres Michigan Chamber of Commerce on April 14. His subject, presented to 250 guests of the Chamber of Commerce, was "Medical Care for All."

* * *

"DOCTOR OF MEDICINE"

Radio Station CKLW—Fridays at 12:45 p.m.

Prepared by the Michigan State Medical Society and sponsored as a Public Service by the Hack Shoe Company.

April 11—M. K. Newman, M.D.	Physical and Occupational Rehabilitation
April 18—Arch Walls, M.D.	The Family Doctor
April 25—Maurice B. Weiner, M.D.	Behavior of Children
*May 2—C. D. Brooks, M.D.	The Importance of Periodic Health Examinations
May 9—Louis J. Gariepy, M.D.	Appendicitis
May 16—C. L. Candler	What is the Wayne County Medical Society?

*Effective May 2, program is presented each Friday at 2:30 p.m.

* * *

Michigan Rural Health Conference.—The Public Relations Committee held a meeting in Lansing, May 9, to plan a Rural Health Conference. Every organization that might be interested in Rural Health in Michigan was invited to send representatives. Thirty-seven persons were present representing thirty-six organizations. It was voted unanimously to hold a rural Health Conference in mid-September; to ask Governor Sigler to be Honorary Chairman. Announcement was made that an invitation had been received to use the Fairchild Theatre (capacity 700) on the Michigan State College Campus for the Conference Assemblies, and the facilities of the College for housing and feeding those in attendance.

* * *

The Ingham County Medical Society held its thirteenth Annual Clinic on Thursday, May 1, 1947, at the Hotel Olds. The excellent program occupied the afternoon and evening: "The Present Status of Streptomycin and Oral Penicillin for Infections of the Urinary Tract," by Russell D. Herrold, M.D., Chicago; "Backache," by Paul C. Williams, M.D., Dallas, Texas; "Problems of Metabolism During Adolescence," by Joseph A. Johnston, M.D., Detroit; "Thrombophlebitis and Phlebothrombosis," by I. Mims Gage, M.D., New Orleans, La.

After the dinner, O. B. McGillicuddy, M.D., president-elect of the Ingham County Medical Society, presented Scrolls of Honor to eighteen members who had been in practice forty years or longer. The evening address was by H. H. Shoulders, M.D., president of the American Medical Association, on "Some Problems in the Field of Medical Economics." The attendance was in the hundreds—most gratifying.

Say you saw it in the Journal of the Michigan State Medical Society

Residents' Night.—The Kent County Medical Society has authorized its Program Committee to submit a plan to the resident staff of the three Grand Rapids hospitals whereby all interns and residents are invited to prepare papers of scientific or clinical interest on a subject of their individual choosing. The three papers most suitable for presentation will be heard by the Kent County Medical Society at a meeting to be known as "Residents' Night" annually in November.

Cash awards to the three successful contestants will be made, and the papers will be submitted for publication.

Congratulations, Kent County Medical Society, and may your worthwhile plan in postgraduate endeavor meet with success.

* * *

Michigan's Disease Prevention Record.—The *Saturday Evening Post* for April 19, 1947, contains a very instructive article by Harold Titus, "You Don't Have to be Sick." It tells of the remarkable work of the Research Laboratories of the Michigan Department of Health, of the pioneering of Dr. C. C. Young, the founder of the laboratory, and of his associates.

The reduction of the high diphtheria death rate to practically nothing, the almost complete elimination of typhoid fever, and the fight on tuberculosis are all dramatically told. The iodized salt story is also told. The article is a deserved boost for a group of well-deserving public servants. Their methods have not always jibed with our understanding, but their results have made Michigan an outstanding health state. The field of preventive medicine, development of vaccines and other precautional methods, is right and proper and full credit is given, but most of the actual immunizing could well be left to the practicing doctor.

* * *

The American Academy of Ophthalmology and Otolaryngology have announced the program of the instruction courses for the October 13, 17, 1947, meeting. Michigan is well represented by contributors to the course: Harold F. Falls, Ann Arbor, Heredity; Bruce Fralick and John Henderson, Ann Arbor, Anatomy of the Orbit; Bruce Fralick, Glaucoma Secondary to Uveitis; Windsor S. Davies, Detroit, Optic Discs—Comparison of Clinical and Pathological Changes; Harold Halls, Ann Arbor, Embryology; J. Conrad Gemeroy, Detroit, External Diseases of the Eye, and Anterior Segment Photography of the Eye; Don Marshall, Kalamazoo, Differential Diagnosis and Treatment of Chronic Infections of the Lid; Elmer L. Whitney, Detroit, Lacrimal Apparatus; Arthur C. Curtis, Ann Arbor, Diagnosis of Common Oral Lesions; A. C. Furstenberg, Ann Arbor, Organic Neurological Considerations of Interest in Rhinolaryngology; James H. Maxwell, Ann Arbor, Surgery of the Parotid Gland; J. M. Robb, Detroit, Proven Procedures in Otolaryngological Office Practice; C. L. Straith, Detroit, Plastic Surgery of Facial Injuries.

* * *

The Fifth Councilor District held a "State Society Night" at the Morton Hotel, Grand Rapids, on May 13.

Cook County Graduate School of Medicine

ANNOUNCES CONTINUOUS COURSES

SURGERY—Two-week intensive course in Surgical Technique starting July 21, August 18, September 22.
Four-week course in General Surgery starting July 7, August 4, September 8, October 6.
Two-week course in Surgical Anatomy & Clinical Surgery Starting July 21, August 18, September 22.
One-week course in surgery of Colon & Rectum starting September 15 and November 3.
Two-week course in Surgical Pathology every two weeks.

FRACTURES & TRAUMATIC SURGERY—Two-week intensive course starting June 16, October 6.

GYNECOLOGY—Two-week intensive course starting September 22, October 20. One-week course in Vaginal Approach to Pelvic Surgery starting September 15, October 13.

OBSTETRICS—Two-week intensive course starting September 8, October 6.

MEDICINE—Two-week intensive course starting October 6.
Two-week course in Gastro-Enterology starting October 20.
One-week course in Hematology starting September 29.
One-month course in Electrocardiography & Heart Disease starting June 16, September 15.
Two-week intensive course in Electrocardiography & Heart Disease starting August 4.

DERMATOLOGY & SYPHILOLOGY — Two-week course starting June 16, October 20.

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The meeting was called to order by M. S. Ballard, M.D., President of the Kent County Medical Society, who turned the meeting over to Councilor J. Duane Miller, Grand Rapids.

The following program was presented:

1. "Medical Matters in Michigan"— Wm. A. Hyland, M.D., Grand Rapids, President, Michigan State Medical Society.

2. "Some Legislative Problems Facing Medicine"— P. L. Ledwidge, M.D., Detroit, President-elect, Michigan State Medical Society.

3. "The Federal Hospital Construction Program"— J. Joseph Herbert, L.L.B., Manistique, General Counsel, Michigan State Medical Society.

4. "Modern Medical Public Relations"—E. R. Witwer, M.D., Detroit, Councilor, Michigan State Medical Society.

One hundred and thirty-seven doctors of the Fifth District were present.

* * *

The Michigan State Pharmaceutical Association, without cost to the Veterans Administration, will from time to time, and by appropriate means, advise the Michigan State Medical Society of the availability of USP and NF products in an effort to establish prescribing practice which will permit the dispensing of the highest quality drugs for veterans at the lowest possible cost to the Veterans Administration.

Following are some of the National Formulary items:

COMPOUND WHITE PINE SYRUP
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White Pine, in moderately coarse powder	85 Gm.
Wild Cherry in moderately coarse powder	85 Gm.
Aralia, in moderately coarse powder	10 Gm.
Poplar Bud, in moderately coarse powder	10 Gm.
Sanguinaria, in moderately coarse powder	8 Gm.
Sassafras, in moderately coarse powder	10 Gm.
Cudbear	1 Gm.
Chloroform	6 c.c.
Sucrose	625 Gm.
Glycerin	100 c.c.
Alcohol	
Distilled Water, a sufficient quantity	
To make	1000 c.c.

AVERAGE DOSE—4 c.c. (approximately 1 fluidrachm).
One average metric dose represents 0.34 Gm. each of White Pine and of Wild Cherry, 40 mg. each of Aralia, Poplar Bud, and Sassafras, 32 mg. of Sanguinaria, and 0.024 c.c. of Chloroform.

WHITE LOTION
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Lot. Alb.	Lotio Sulfurata
Zinc Sulfate	40 Gm.
Sulfurated Potash	40 Gm.
Distilled Water, a sufficient quantity	
To make	1000 c.c.

ALKALINE SULFUR OINTMENT
Unguentum Sulfuris Alkalinum
Ung. Sulfur. Alk.

Sublimed Sulfur	200 Gm.
Potassium Carbonate	100 Gm.
Water	50 Gm.
Wool Fat	40 Gm.
Yellow Wax	40 Gm.
Petrolatum	570 Gm.
To make	1000 Gm.

STRAMONIUM OINTMENT
Unguentum Stramonii
Ung. Stramon.

Pilular Stramonium Extract	100 Gm.
Diluted Alcohol	50 c.c.
Wool Fat	50 Gm.
Yellow Wax	50 Gm.
Petrolatum	750 Gm.
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Sodium Salicylate	85 Gm.
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To make	1000 c.c.

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The Wayne County Medical Society elections were held May 5. Douglas Donald, M.D. was elected to succeed as President for the year 1948-49, President C. L. Candler, M.D., who began his tenure May 6, 1947. E. C. Texter, M.D. was chosen as Secretary and E. D. Spalding, M.D. was elected as Trustee.

The following Delegates to the Michigan State Medical Society House of Delegates were elected: R. L. Novy, M.D., Douglas Donald, M.D., Grover C. Penberthy, M.D., Charles S. Kennedy, M.D., Wyman D. Barrett, M.D., T. K. Gruber, M.D., S. W. Insley, M.D., William Bromme, M.D., E. D. Spalding, M.D., D. C. Beaver, M.D., Arch Walls, M.D., W. W. Babcock, M.D., R. H. Pino, M.D., W. B. Harm, M.D., J. J. Lightbody, M.D., C. I. Owen, M.D., F. A. Weiser, M.D., W. J. Cassidy, M.D., E. A. Osius, M.D., M. A. Darling, M.D., Harold Kullman, M.D., Wm. J. Stapleton, Jr., M.D., E. G. Krieg, M.D., A. E. Catherwood, M.D., B. H. Douglas, M.D., H. F. Dibble, M.D., L. J. Morand, M.D., W. F. Seeley, M.D., L. J. Bailey, M.D., C. K. Hasley, M.D., F. G. Buesser, M.D., D. C. Somers, M.D., W. L. Brosius, M.D., J. A. Kasper, M.D., R. A. Johnson, M.D., Lawrence Pratt, M.D., H. B. Fenech, M.D., Charles Lemmon, M.D., R. V. Walker, M.D., L. J. Gariepy, M.D., H. L. Morris, M.D., E. C. Texter, M.D.

* * *

"Parergon" ("Work by the Side of Work") contains illustrations of thirty-three artistic creations by Michigan physicians. The third edition of *Parergon,* published by Mead Johnson & Co. of Evansville, Indiana, presents the work of the following M.D.s of this State:

W. C. Behen, M.D., Lansing, oil painting—"Life In Mexico;" Bernard J. Beuker, M.D., East Jordan, oil—"The Janitor's Portrait;" G. Clare Bishop, M.D., Almont, photograph—"Sponge Diver;" Morris Braverman, M.D., Detroit, leather tooling—"Picture Frame;" Philip N. Brown, M.D., Ypsilanti, pastel—"Signorina Superba."

W. Alan Chickering, M.D., Fort Custer, wood carving—"Dorothy;" G. H. Cook, M.D., Ionia, pastel—"Back."

D. C. Durman, M.D., Saginaw, oil—"Lincoln."

Arvard Fairbanks, M.D., Ann Arbor, plaster—"Relief Children of Dr. Furstenberg;" W. W. Fosget, M.D., Lansing, water color—"Pal;" W. M. Foster, M.D., Detroit, photograph—"Glacier Trail."

W. E. B. Hall, M.D., Port Huron, plaster mold impression—"Leaf Spray;" Ruth Herrick, M.D., Grand Rapids, photograph—"Rural School;" T. V. Hoagland, M.D., Ypsilanti, water color—"Suspended Animation;" R. K. Hollingsworth, M.D., Ann Arbor, metal arts—"Table Console."

W. B. Johnson, M.D., Detroit, pastel—"West Vidette."

Hardy A. Kemp, M.D., Detroit, oil—"Untitled."

Norman L. Lindquist, M.D., Manistique, photograph—"Iron Ore;" M. B. Llewellyn, M.D., Detroit, needle work—"Coat of Arms."

Hazen L. Miller, M.D., Detroit, oil—"O.P.D.;" Sallie W. Miller, M.D., Port Huron, oil—"Eucalyptus-California."

Anderson Nettleship, M.D., Detroit, oil—"Peace, Men Returning from Work."

Charles W. O'Dell, M.D., Ann Arbor, pastel—"Collie;" Constantine Oden, M.D., Muskegon, photograph—"Mary Lind."

Russell Palmer, M.D., St. James, oil—"Winter Landscape;" Hermann Pinkus, M.D., Monroe, color photograph—"At the Old Water Wheel."

Harold F. Raynor, M.D., Detroit, metal arts—"Tray;" Francis F. Rosenbaum, M.D., Ann Arbor, photograph—"At Spring Mill."

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"Arthur L. Stanley, M.D., Lansing, wood carving—"Human Skeleton;" Bert E. Stofer, M.D., Detroit, photograph—"Snooty."

Julius C. Tapert, M.D., Grosse Pointe, wood carving—"My Wife;" G. W. Trumble, M.D., Mt. Morris, oil—"Returning Spring."

H. F. Warden, M.D., Dearborn, oil—"Marine;" W. H. Winchester, M.D., Flint, photograph—"Portrait in Sanguine."

* * *

WELCOME, DOCTORS!

The Michigan State Medical Society is happy to welcome the following newly elected members reported during April, 1947, by the indicated component county medical societies:

Allegan County
Baker, A. G., Allegan

Alpena-Alcona-Presque Isle County
Arscott, E. F., Rogers City
Foley, Arthur L., Rogers City

Branch County
Atkinson, A. L., Quincy

Calhoun County
Hollands, Robert A., Battle Creek
Strohmenger, Frank J., Albion

Chippewa-Mackinac County
Finlayson, D. D., Sault Ste. Marie
Goldberg, A. H., Sault Ste. Marie
Harris, D. M., Sault Ste. Marie
Howe, Gertrude, Sault Ste. Marie
Trapasso, T. G., Sault Ste. Marie

Dickinson-Iron County
Palm, E. Theodore, Crystal Falls

Eaton County
Harrod, Gordon, Grand Ledge
Meinke, Albert, Eaton Rapids
Whitlock, S. C., Dimondale

Genesee County
Benson, John C., Jr., Flint
Beyer, Damon P., Clio
Conover, McClellan, Flint
Knapp, William D., Flint
Sparks, Harvey D., Flint
Westcott, George F., Goodrich

Hillsdale County
Wiggins, I. W., Jonesville

Ingham County
English, Lena, East Lansing
Harrison, Wm. H., Lansing
Snyder, Ruth Ellis, East Lansing

Jackson County
Stone, E. L., Jackson

Kalamazoo County
Barak, Herbert G., Kalamazoo
Rogers, T. P., Kalamazoo
Russell, Stuart, Kalamazoo

Kent County
Boldyreff, Ephraim, Grand Rapids
Clawson, Carroll K., Grand Rapids
Doezema, Edward R., Grand Rapids
Kelly, Edward F., Grand Rapids
Maynard, Mason S., Grand Rapids
Sevensma, Eugene S., Grand Rapids
Sugyama, Titsuo, Grand Rapids

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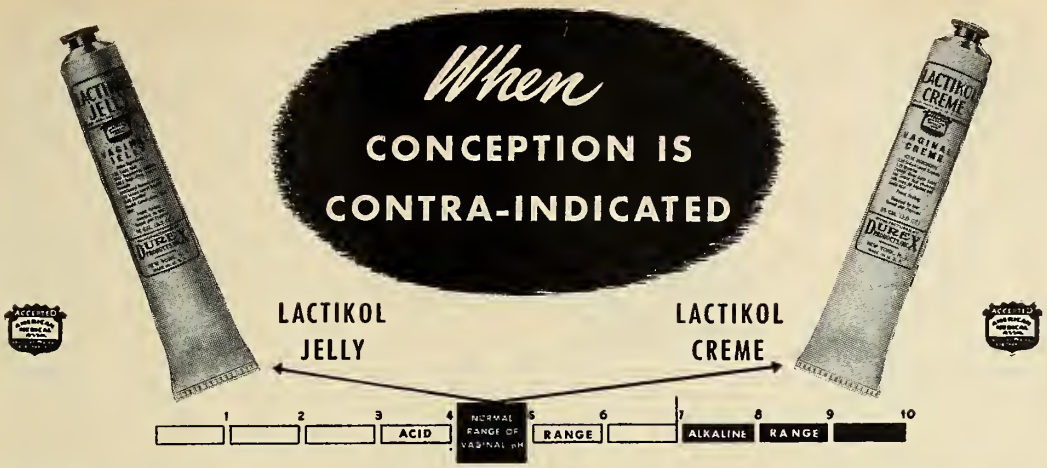

pH VALUE. The normal vaginal pH lies between 4.0 and 5.0. Both Lactikal Jelly (pH 4.15) and Lactikal Creme (pH 4.9) are within this normal range and so tend to maintain the proper pH value of the vaginal tissues.

SPERMICIDAL POWER. Both Lactikal Jelly and Lactikal Creme immobilize sperm instantly on contact.

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LUBRICITY. Lactikal Jelly with a vegetable gum base, provides a highly lubricating medium. Lactikal Creme with a cream base, is less lubricating. The choice between these lies with the preference of the patient.

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ACTIVE INGREDIENTS. Lactikal Jelly: Lactic Acid, 1.5%; Glyceryl Monoricinoleate, 1.0%; Sodium Lauryl Sulfate, 0.2%; Oxyquinoline Sulfate, 0.05%.

Lactikal Creme: Lactic Acid, 0.5%; Glyceryl Monoricinoleate, 1.5%; Sodium Lauryl Sulfate, 0.6%.

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Hefferon, Charles, Adrian
Isley, H. E., Blissfield
Whitehouse, L., Morenci

Macomb County
Jewell, James H., Roseville

Manistee County
Lalime, Ruth E., Bear Lake
Murphy, Frank E., Cadillac

Mecosta-Osceola-Lake County
Nelson, Lorenzo, Baldwin

Medical Society of North Central Counties
Forney, F. A., Gaylord

Muskegon County
Greene, Henry Philip, Muskegon
Joistad, A. H., Muskegon
Smith, Luther, Muskegon
Toy, Charles, Muskegon
Williams, E. V., Muskegon Heights

Oakland County
Bannow, Robert J., Pontiac
Ruva, Joseph, Pontiac
Wake, Douglas L., Royal Oak

Saginaw County
Bucklin, Robert, Saginaw

Tuscola County
Ballard, James H., Cass City
Lamberti, Thomas G., Caro

Washtenaw County
House, Frederic B., Ann Arbor

Wayne County
Anderson, William, Northville
Bott, Edmund T., Wyandotte
Charnas, Sidney, Detroit
Cowley, Leonard L., Detroit
Crane, Thomas P., Dearborn
Elman, Meyer J., Detroit
Hand, Fordus V., Detroit
Smyka, Edward J., Detroit

BARTENDER'S HEALTH EXAMINATION

The Michigan Liquor Control Commission has adopted a law (ruling) which requires that bartenders, who must renew their licenses each year, must obtain a certificate of health signed by a physician and an officer of the Board of Health. The certificate must show that the applicant is not affected with any infectious or communicable disease.

INVALID FOOD NOURISHES WITH LESS NITROGEN CONTENT

The old-time rhymester who wrote, "I cannot eat but little meat" should have attended the meeting of the American Chemical Society's division of medicinal chemistry. A new food preparation, described as a hydrolyzate of casein, was declared by Dr. Charles F. Kade, Jr., of Frederick Stearns and Company, to be able to maintain the necessary protein nourishment of weakened patients at a lower nitrogen inake than usual. This enables such patients to rebuild their tissues with a minimum load on their digestive organs.

—*Science News Letter,* May 17, 1947

ARTIFICIAL LIMBS

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$50.00 weekly indemnity, accident and sickness — *Quarterly*

$15,000.00 accidental death.....$24.00
$75.00 weekly indemnity, accident and sickness — *Quarterly*

$20,000.00 accidental death.....$32.00
$100.00 weekly indemnity, accident and sickness — *Quarterly*

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$200,000.00 deposited with State of Nebraska for protection of our members.

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THE DOCTOR'S LIBRARY

Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

UTERINE CONTRACTILITY IN PREGNANCY. A Study of the Contractions of Pregnancy and Labor Under Normal and Experimental Conditions. By Douglas P. Murphy, M.D., F.A.C.S., Assistant Professor of Obstetrics and Gynecology, and Research Associate in the Gynecean Hospital Institute of Gynecologic Research, University of Pennsylvania. 64 Illustrations. Philadelphia: J. B. Lippincott Co., 1947. Price $5.00.

This is a new book on a more or less previous problem of uterine contractility, based on individual records of uterine contractions during pregnancy and labor. His observations throw light upon the significance of these contractions, with conclusions that are of practical and clinical value.

The labor contractions observed during his investigation, and the conclusions reached, aid in distinguishing between inertia and dispoportion as causes of prolonged labor.

Dr. Murphy also describes various contractions of the uterus produced by the more commonly used drugs in OB practice, such as pituitary extract, morphine, and estrogenic substances, and he indicates a proper selection of oxytocic drugs in uterine inertia.

Numerous minor complaints of the prenatal patient in regard to uterine contractions, both normal and abnormal, are discussed.

The book, in general, is a practical, scientific report on the contractility of the uterine musculature which should prove of value to all physicians practicing obstetrics.

F.J.M.

HAROFE HAIVRI. The Hebrew Medical Journal, Vols. I and II, 1946, 983 Park Ave., New York, N. Y.

Harofe Haivri is dedicated to the continued growth of Hebrew medical literature.

The medical section contains the following articles: "Renal Lithiasis and Its Treatment" and "Urinary Tract Infections" by Abraham Hyman, M.D., "The Menopause, an Endocrine Dysfunction" by Raphael Kurzrok, M.D., and "The Present Conception of the Treatment of Anemias" by Gershon Ginzburg, M.D.

Dr. M. Sherman of Tel Aviv writes on the Palestine Jewish Medical Association (PJMA) of which he is president. This association was organized in 1912 with a membership of eleven physicians. Today, its members number 2,300. Its functions are similar to the AMA activities in America. The Association does not limit its activities and interests to scientific and professional matters. It is equally concerned with the health problems of the population of the country.

The sections on historical medicine contain two articles by Dr. Z. Muntner; one on the great physician and philosopher, Sabbathai Donnolo who lived in the 10th century and contributed much to the renaissance of medicine in Italy, and the other on the ethics of the Jewish physicians in the ancient Hebrew literature.

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GYNECOLOGICAL AND OBSTETRICAL PATHOLOGY, With Clinical and Endocrine Relations. By Emil Novak, A.B., M.D., D.Sc. (Hon. Dublin), F.A.C.S., Associate in Gynecology, Johns Hopkins Medical School; Gynecologist, Bon Secours and St. Agnes Hospitals, Baltimore; Fellow, American Gynecological Society, American Association Obstetricians, Gynecologists & Abdominal Surgeons, and Southern Surgical Association; Honorary Fellow, Societe Francaise de Gynecologie; Royal Institute of Medicine, Budapest; Sociedad d'Obstetricia et Ginecologia de Buenos Aires; Central Association of Obstetricians & Gynecologists; Texas State Association Obstetricians and Gynecologists; Past Chairman. Section on Gynecology and Obstetrics A.M.A. Second edition, with 542 illustration, 15 in color. 570 pages. Philadelphia and London: W. B. Saunders Company, 1947. Price $7.50.

Dr. Novak's new book again presents numerous scientific and practical descriptions of the most common pathological problems encountered by the specialist, and common practitioner, in the obstetrical and gynecological field. It is a book that contains a thorough review of these conditions, and should be mastered by all doing obstetrics and gynecology.

F.J.M.

PRINCIPLES AND PRACTICE OF OBSTETRICS. By Joseph B. DeLee, M.D., Late Professor of Obstetrics and Gynecology, the University of Chicago; Consultant in Obstetrics, the Chicago Lying-in Hospital and Dispensary; and J. P. Greenhill, M.D., Attending Obstetrician and Gynecologist, the Michael Reese Hospital; Obstetrician and Gynecologist, Associate Staff, the Chicago Lying-in Hospital; Chairman, Dept. of Gynecology, Cook County Hospital; Professor of Gynecology, Cook County Graduate School of Medicine. 9th Edition. 1011 pages; 1108 illustrations on 860 figures, 211 in color. Philadelphia and London: W. B. Saunders Company, 1947. Price $10.00.

This volume is the ninth edition of the great standard DeLee work brought up to date by J. P. Greenhill, Dr. DeLee's successor. It is a teaching volume as well as a standard text and guide for obstetricians and general practitioners who are doing obstetrics. New chapters on Minor Disturbances of Pregnancy, Premature, Prolonged or Missed Labor, Fetal Erythroblastosis, Care of Premature Babies, have been added and ten old chapters replaced. The contents of the book have been prepared with an eye to practicability as well as service. Always the DeLee volume is a great book.

RECENT ADVANCES IN CLINICAL PATHOLOGY. By Various Authors, produced under the auspices of the European Association of Clinical Pathologists. General Editor, S. C. Dyke, D.M. (Oxon), F.R.C.P. (Lond.) Section Editors, Bacteriology, R. Cruickshank, M.D. (Aberd.), F.R.C.P. (Lond.); Biochemistry, E. N. Allott, B.Sc., B.M., B.Ch. (Oxon), F.R.C.P. (Lond.); Haematology and Cytology, B. L. Della Vida, M.D. (Rome); Histology, A. H. T. Robb-Smith, M.D. (Lond.). With 34 plates and 19 text figures. Philadelphia-Toronto: The Blakiston Co., 1947. Price $5.50.

Forty well-known European clinical pathologists have co-operated to produce this book. The purpose of Clinical Pathology in Great Britain has been to bring the laboratory into direct contact. The laboratory is the instrument and has its application throughout the whole of medicine.

Each author has a chapter covering: Bacteriology, Biochemistry, Haematology and Cytology, and Histology.

Short cuts and approved newer methods of investigation are emphasized. Techniques of procedure and the application of findings are well handled.

This is a handy, small-sized text for general use.

THE PHARMACOPOEIA OF THE UNITED STATES OF AMERICA (The United States Pharmacopoeia). Thirteenth Revision (U.S.P. XII) by authority of the United States Pharmacopoeial Convention. Prepared by the Committee of Revision and published by the Board of Trustees. Official from April 1, 1947. Easton, Pa.: Mack Publishing, 1947.

This volume is the thirteenth edition completely rewritten and brought up to date as of April 1, 1947. There is a list of articles added to the United States

Say you saw it in the Journal of the Michigan State Medical Society

Pharmacopoeia, and a list of those deleted. The list of deletions includes Serum Antimeningococcecum, Serum Antipneumococcecum, Serum Immune Scarlatina Hamanum, et cetera, which probably represents the rapid growth of biotics.

The Pharmacopoeia is a vast archive of drug information, sources, compounding and uses. No pharmacist can be without it, and it is a valuable reference for the doctor who is prescribing.

PUBLIC RELATIONS CHECK LIST FOR PHYSICIANS

Do I bill my patients regularly so they can plan and adjust their personal finances to meet the cost of medical care?

Do I send my delinquent accounts to a collector who will extract my fee regardless of the reasons for the delinquency or of the consequences to my patients?

In setting my fee, do I make any current medical, dental, and hospital expenses for his family so that my charge is based upon the relation of the *entire* medical expense to the patient's ability to pay?

Am I giving each individual patient the best medical care and service of which I am capable?

Am I trying to crowd too many people into too short a time to permit me to practice good medicine?

Am I sufficiently willing to admit my limitations as to time and training and refer my patients to qualified physicians in my own or other fields when necessary?

Are my charges absolutely fair and commensurate with the work performed?

Do I discuss my charges frankly with my patients at the time, or before the work is done? Do I invite discussion as to his ability to meet those charges?

Do I adjust my charges on an emotional basis or on that of a *competent investigation* of the patient's ability to pay?

Do I instruct my patients on the benefits of hospital and health insurance?

Do I consider my patient's time as important to him as mine is to me and so plan my schedule that he is not kept waiting for an unreasonable period?

Do I respect my patient's faith in my integrity by having him return for subsequent treatments only when necessary?

Have I done everything possible from my standpoint to create a feeling of his relationship with me?—*The Bulletin of the Alameda County Medical Association.*

EMIC ENDS

The EMIC program terminated June 30—for all cases which did not become eligible prior to that date.

Another "grand experiment" has come to an end—with lots of tax money paid out.

HOSPITAL RECORDS

Doctors, some of them, are notoriously averse to keeping hospital records. But such records must be kept. It is claimed that a busy doctor cannot remember, legally, what he did for a patient if he waited two whole days before making the record. Yet how many wait for a week, or until they "have time"? Hospitals are being removed from the approved list of the AMA for laxity in hospital records. We have a duty.

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EARLY RECOGNITION OF CARCINOMA OF THE COLON AND RECTUM

(Continued from Page 682)

In conclusion let me repeat that on account of the alarming prevalence of malignancies of the rectum and colon, one must keep in mind as a possible early danger signal any one or combination of the symptoms mentioned above, which are:

Change in intestinal habit, such as irregularity.
Loss of appetite.
Lassitude.
Indigestion.
Abdominal distention, relieved by the passage of considerable flatus.
Increase in intestinal activity.
Passage of mucus, later streaked with blood.
Hemorrhage, either slight or massive.
Gradual loss of weight, and later pain.

I am happy to state that on account of an awakening consciousness in our profession, more and more patients suffering from malignancy are being discovered early enough so that the number of five-year cures is being increased by leaps and bounds.

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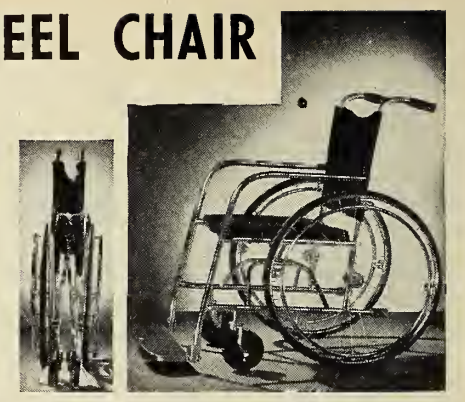

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MICHIGAN'S DEPARTMENT OF HEALTH

Personal Items

(Continued from Page 704)

Service in 1945, has accepted a residency in clinical tuberculosis at Pinecrest Sanatorium, Powers.

Arthur G. Baker, M.D., has been appointed Director of the Allegan County Health Department. A graduate of the University of Michigan School of Medicine, he had experience in private practice and public health in Kentucky, and spent the past year as a Kellogg Foundation fellow in the Calhoun County Health Department.

* * *

Robert F. Hall, M.D., has been appointed Director of the Isabella County Health Department. A former director of the Bay City Health Department, he entered military service in 1942. Returning, he became associated with the Mott Foundation.

* * *

V. L. VanDuzen, M.D., has resigned as Director of the Mecosta-Osceola District Health Department.

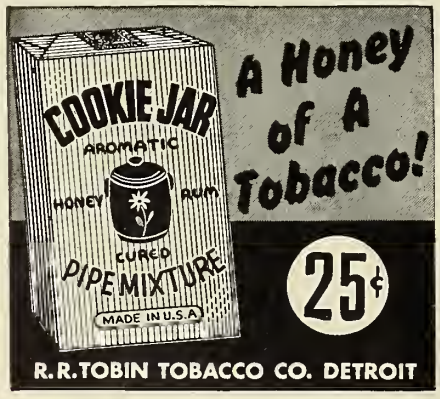
Harry Vivian has joined the staff of the Houghton-Keweenaw-Baraga Health Department as assistant sanitarian. He is a graduate of the Michigan College of Mining and Technology, Houghton.

* * *

Col. Stuart Friant, who has been a member of the staff of the Michigan Department of Health for the past twenty-five years and director of the Bureau of Records and Statistics for nine years, has resigned, effective May 15.

Colonel Friant came to the Michigan Department of Health in October, 1922. He served in all positions from clerk to Director of the Bureau of Records and Statistics. As Director of the Bureau, he succeeded the late Dr. W. J. V. Deacon in 1938.

Colonel Friant served with the Polar Bears in World War I and as Adjutant General of the 32nd Infantry Division, Michigan National Guard, in World War II. He saw continuous service with the Michigan National Guard from June 1, 1922, to May 1, 1947, when he was retired, for physical disability incurred in line of duty, with the rank of colonel.



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CRISIS BRITAIN

The following excellent editorial appeared in *The Bulletin of the Genesee County Medical Society* of February 25, 1947, of which A. C. Pfeifer, M.D., Flint, is Editor:

We should be intensely interested in the Socialist government of England, prettily camouflaged as a "Labor" government. There are some of us who would hold it up to the rest of us as a model for our own improvement, especially in regimentation of the practice of Medicine.

According to an editorial in the *New York Times* of February 9, 1947, England faces the gravest domestic crisis of her last twenty years. Threatened economic chaos causes a dangerous sag to imports vital to the people's daily life. Every home will suffer greater and heavier hardships.

That the situation rises from the very nature of the Socialist government which has been in power since 1945, is obvious since the government has for some time been drifting toward a crisis. The structure of British economics has been profoundly altered while life in England has not grown easier. The people are subject to more restrictions than they were during the war.

While the economic status of the nation has not improved, the people have grown more girmly submissive. For, have they not been told again and again that the Labor government is their very own? Submission—the first step toward absolute regimentation. They are told that their plight is the inevitable result of war. For the first time the government finds itself on the defense. It is trying to avoid another general election at this time by requesting more submission, more patient suffering—the British version of one five-year plan after another.

But we fear (we hope) that Mr. Atlee isn't tough enough. He doesn't have enough of that old Stalin in his backbone. Poor Mr. Atlee, unlike a former ruler of Britain who offered his Kingdom for a horse, is in the market for an alibi—with one horse on him now.

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What it feels like when your first-born needs an expensive doctor—and you can't afford it . . .

What it's like wanting a home of your own . . . and never quite getting it . . .

What it's like having your kids grow up not knowing whether they'll ever get to college . . .

What it's like to see your friends able to travel abroad—but never you . . .

What it's like to have to keep telling yourself, "He may not have money, but he's my Joe."

There is no cure-all for all these things.

But the closest thing to it for most of us is something so simple you almost forget it's there.

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So if you're a newlywed or know one, here's a bit of friendly advice to take or give:

Get on the Payroll Savings Plan where you work or the Bond-a-Month Plan where you bank.

It's one of the finest things you can do to start married life right.

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*Morton, D. J., "The Human Foot" (page 175), Columbia University Press, 1935.

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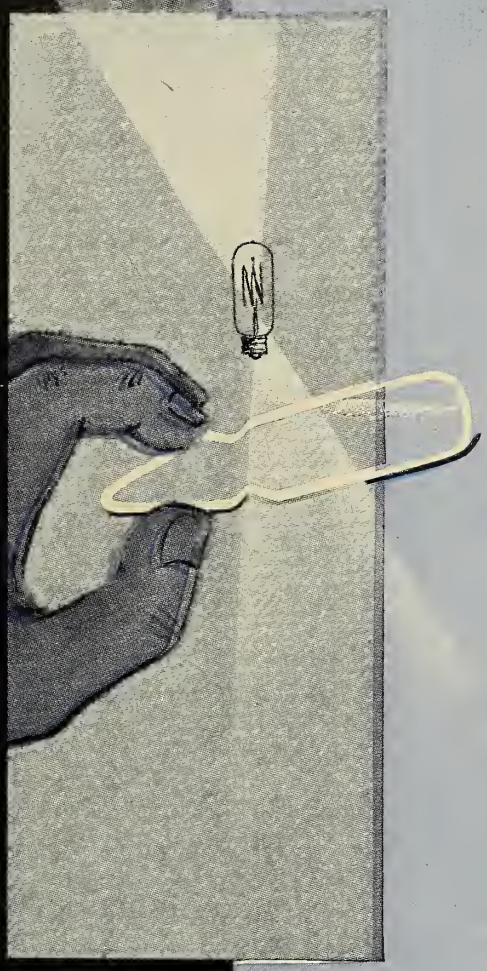

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MSMS ANNUAL SESSION—GRAND RAPIDS September 23-26, 1947

Doctor, you are cordially invited—you are urged—to attend the 82nd Annual Session of your State Medical Society, in Grand Rapids next September. Hotel reservation blank will be found on Page 838.

The Program (and what a Program!) appears on Page 822.

The Pere Marquette Streamliners offer convenient transportation for those physicians who reside in the southeastern part of the state as the MSMS Program has been arranged from Tuesday noon to Friday noon, September 23-26. Arrange your railroad reservations as early as possible.

A QUARTER MILLION DOLLARS LOST TO MICHIGAN PHYSICIANS

If Michigan Doctors of Medicine fail to bill the Michigan Crippled Children Commission *direct* for medical treatment of afflicted and crippled children, they are insuring that a sum approximating $250,000 per annum is lost to them.

The 1947 Michigan Legislature amended both the Afflicted and the Crippled Children Acts so that "any physician or surgeon except residents treating any such child at any hospital . . . shall bill the Commission for compensation as fixed by the Commission and paid by a separate warrant drawn to his order. . . . "Professional fees shall not exceed $90 for a major operation and in no case shall surgical and/or medical fees exceed $200 to any one doctor for any one patient in a twelve-month period. Said . . . physician shall make and file with the Commission affidavits containing *itemized* statements of such services rendered. . . . The compensation as fixed and approved by the Commission shall be paid to the physician or surgeon performing the services hereunder by a separate warrant drawn to his order and forwarded to him at his professional address. . . ."

The new features of the Afflicted and Crippled Children Laws are:

(a) the doctor shall send *itemized bills direct* to the Crippled Children Commission (not through the hospital, as in the past).

(b) The Auditor General forwards the doctor's check for services to his professional address (not to the hospital, as in the past).

(c) The top limitation on medical fees is $90 (not $75, as in the past). It to be stressed that the Commission is to be billed within sixty days of the date services are rendered. Bills received by the Commission after sixty days cannot be paid legally.

The new amendments to the Crippled and Afflicted Children Acts become effective October 11, 1947.

S. 545 (TAFT-BALL-SMITH-DONNELL HEALTH BILL), ENCOURAGES VOLUNTARY MEDICAL PLANS

E. F. Sladek, M.D., Traverse City, Chairman of the MSMS Council, represented the Michigan State Medical Society at the hearings on S. 545 in Washington, June 6. The Taft Health Bill would aid voluntary prepaid medical care plans and other voluntary methods of medical practice in contrast to the compulsory regimentation programs outlined in other proposals before Congress, particularly the Wagner-Murray-Dingell Bill.

SIGNALS! 140-712-1310!

These are not football signals. They are the numbers of bills in the United States Senate—bills that vitally affect each and every doctor of medicine in the practice of his profession.

S.B. 140 is opposed by the Michigan State Medical Society because it would place a nonmedical intermediary between the health division of the proposed department (Health, Education, and Security) and the President of the United States.

S. 712, the Aiken Bill, would reconstitute the Federal Security Agency as a department of cabinet stature. This bill seems to be inspired by the same social welfare group which advocated the Wagner-Murray-Dingell Bills of past years.

S. 1310 is the new 1947 Wagner-Murray-Dingell Bill. The latest co-sponsors include Senators

(Continued on Page 744)

Continue until weaning...

No substitute for mother's milk is more highly regarded than Similac for feeding the new born, twins, prematures, or infants that have suffered a digestive upset. Similac gives uniformly good results in these special cases simply *because it resembles breast milk so closely.* Normal babies thrive on it *for the same reason.*

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SIMILAC *Similar to breast milk*

SIGNALS!

(Continued from Page 742)

Pepper, Chavez, Taylor and McGrath. S. 1310 has added a sugar-coating to its lethal lining by inserting some alleged "grass roots" controls. Its introduction in late May was augmented by another message to Congress from Mr. Truman who urged "a national health insurance program for all persons: (1) to pay their necessary hospital and doctor bills (and dentist bills too); (2) to reimburse them, at least in part, for earnings lost by "illness or disability not connected with their work."

The *Detroit Free Press* of May 20 ends its story on Mr. Truman's message with the pertinent observation: "The message left to Congress the details as to just who would pay the premiums!"

MEDICAL PUBLIC RELATIONS VIA THE RADIO

A big public relations job is being done by the Michigan State Medical Society in the field of radio. The state-wide schedule of radio presentations sponsored by your State Medical Society, in co-operation with local radio stations, agencies and firms, as of June 1, 1947, included three programs, as shown below.

"A LOT OF" MEDICAL CHARITY

Says Florida's Senator Claude Pepper at the hearings on S. 545: "I think a lot of this charity service that is talked about is a lot of hooey, and I think a lot of poor people can prove it."

Senator Pepper doesn't have "a lot of" charity in his heart for the medical profession.

The charity a physician does becomes part of his confidential relationship with his patients. Were it publicized, it would lose its character as charity and become merely the overt publicity activity of a gratitude-seeking benefactor.

A conservative estimate of the number of hours given each year by doctors of medicine to hospitals, clinics, etc., etc., is $1,000,000 per day (not per year, not per month, not per week—but *per day!*).

The most righteous of the left-wingers in Congress, including Senator Pepper, cannot deny that $365,000,000 per annum is a large contribution to charity—greater than is being given by any foundation or individual the world over. However, left-wingers will discredit even $365,000,000 worth of charity in their frenzied efforts to foist socialized schemes, quietly and surreptitiously, on a seemingly disinterested U. S. public. They bitterly resent the introduction of *truth,* presented by the medical profession and others, into hearings before congressional committees.

(Turn to Page 746)

CITY	STATION	TIME	M	T	W	T	F	S	S
1. "TELL ME, DOCTOR" (Five minutes)									
Grand Rapids	WLAV	6:15 p.m.	x	x	x	x	x	x	x
Battle Creek	WELL	6:10 p.m.—Sun. 8:25 p.m.	x	x	x	x	x		
Port Huron	WHLS	1:35 p.m.	x	x	x	x	x	x	
Lansing	WJIM	10:15 a.m.	x	x	x	x	x	x	
Detroit	CKLW	9:45 a.m.	x	x	x	x	x		
Kalamazoo	WKZO	8:40 a.m.		x		x			
Cadillac	WATT	8:20 p.m.	x	x	x	x	x		
Iron Mountain	WMIQ	4:55 p.m.	x	x	x	x	x		
Ludington	WKLA	9:55 a.m.	x	x	x	x	x		
Marquette	WDMJ	11:30 a.m.	x	x	x	x	x		
Jackson	WIBM	12:15 p.m.						x	
Alpena	WATZ	4:30 p.m.	x	x	x	x	x		
Calumet	WHDF	9:30 a.m.	x	x	x	x	x	x	
Lapeer	WMPC	10:15 p.m.	x	x	x		x		
2. "DOCTOR OF MEDICINE" (Ten minutes)									
Detroit	CKLW	2:30 p.m.					x		
3. "MEDICAL TALKS" (Fifteen minutes) (Michigan State Medical Society and University of Michigan joint project)									
Detroit	WJR	10:15 p.m.						x	
East Lansing	WKAR	2:30 p.m.	x						
Iron Mountain	WMIQ	7:15 p.m.		x					

DO YOU KNOW WHAT THESE SYMBOLS STAND FOR?

In medieval times, the dragon was the symbol of the chemist and apothecary. Ancient alchemists were said to use dragon's blood in their potions, and the dragon came to mean certain chemical actions. An apothecary advertised his wares to the world by painting a dragon on a drug pot, and hanging it over his door.

Today it is the familiar Rexall sign which assures you of superior and dependable pharmacal service. Displayed over more than 10,000 independent drug stores throughout the country, the Rexall symbol on drugs means pure, potent and uniform drugs, laboratory tested under the rigid Rexall system of controls. It means unexcelled pharmacal skill in compounding them.

Rexall

DRUGS

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REXALL DRUG COMPANY

LOS ANGELES, CALIFORNIA

PHARMACEUTICAL CHEMISTS FOR MORE THAN 44 YEARS

(Continued from Page 744)

P R SUPPLEMENT

Supplement No. 1 to the MSMS Public Relations Plan covering the "Newspaper Advertising and Publicity Program" has been mailed to all members of the Society. You are invited to keep this Supplement, together with the Public Relations Plan issued last year, for easy reference.

A COMPARISON OF HOSPITAL COSTS, 1940-1947

Because of unwarranted criticism of present hospital rates, the cost of hospital materials, drugs and labor is presented below. The year 1940 is used because on the following years prices began to rise, have risen ever since and are still rising. The figures are those of The Grace Hospital (Main) but they might just as well be those of any other hospital—prices and costs are very similar throughout the Detroit area.

Description	1940	1947	Remarks
Bed Sheets (63x108), Per Doz.	$ 6.72	$ 25.98	Practically unobtainable.
Surgeons' Gowns, Per Doz.	9.90	24.63	Practically unobtainable.
Gauze—36 In. x 100 Yd. Bolt	2.80	4.70	Critical item.
Cat Gut—Per Doz.	2.30	3.14	Critical item (glass shortage).
Butter—Per Pound	.30	.75	Critical item.
Canned Cherries—Per Doz. No. 10 Can	10.50	21.00	Practically unobtainable.
Pork Loin—Per Pound	.17	.55	Unobtainable at times.
General Duty Nurses (48-Hour Week)	102.50		40-Hour Week necessitates an
General Duty Nurses (40-Hour Week)		200.00	increase of 16% in number of nurses.
Cost Per Patient Day	5.41	14.62	Cost has tripled.
Room Rates			
Wards	4.00	8.50	Rates have doubled.
Semi-private Rooms	5.00	10.00	Rates have doubled.
Private Rooms	10.00	17.00	Rates have doubled.

It should be noted that costs have increased two and one-half to three times while rates have increased approximately two times only. Hospitals try to bring back health to patients, to give good service, to aid and supplement the physician in his work and *to break even.*

The above statistics are presented that you as a physician may give to your patients an accurate picture of the why of hospital rates and where their hospital dollar goes.—*Detroit Medical News,* April 21, 1947.

THE PROBLEM IS OURS

The increase in rates announced by the hospitals of the metropolitan district has precipitated some discussion as to the effect it may have in swaying the opinion of an already socialized medicine-minded public toward a demand for some form of government medicine.

The need for the increase in rates is evident from a study of the figures of 1940 and 1947 published on the opposite page. It is obvious that hospitalization costs are soaring beyond the reach of the uninsured patient of moderate means and that prolonged hospitalization may be prohibitive even though he has insurance. Thus there may come to pass a redefinition of the charity patient who, in the jargon of the sociologist, has already been prechristened a "ward of the government."

The solution of this problem is ours—we will accomplish nothing constructive by damning the hospital management. Expenses are met from the money collected from patients. There are no longer any private donors of funds.

It isn't fair to compare hospital costs to hotel costs. Good hotels employ one worker for each 2.5 to 3.0 guests, while good hospitals employ two workers for each (one) patient. Furthermore, hospitals as yet have not taken to owning and profiting from cocktail lounges. Neither is it logical thinking when criticism is directed at the cost of training interns, nurses and residents. The modern hospital is a public service institution dedicated to the protection of the health of the community it serves. It is the repository, through its staff, of the medical knowledge, and through its physical equipment, of the best of the diagnostic and therapeutic aids. It must prepare the young physician for practice and provide a source of knowledge for the practicing physician. A hospital that functions only as a workshop for the physician is not serving the common good.

Relief from high costs must come from monies donated either by private individuals or by the government to supplement the income of the hospitals. Our present income and gift tax setup makes it prohibitive for private citizens to give amounts sufficiently large to affect the cost picture, hence it appears aid will have to come from tax monies either through grants directly to hospitals or by the building of government owned and managed institutions.

A more efficient method would be to free donations, to accredited hospitals, of the gift tax and permit their deduction from the income tax. Thus the full amount would go to the hospital (and hence to the public) without the erosion that occurs when monies flow through government channels.— Frank A. Weiser, M.D., Editorial, *Detroit Medical News,* April 21, 1947.

Editor's Note: This editorial and the comparison of costs is so eminently timely and fair that we are glad to reproduce it for the benefit of all our members throughout the State.

(Continued on Page 748)

KAPSEALS®
50 mg. each, in bottles of 100 and 1000.

BENADRYL® hydrochloride

The results of a recent survey of the clinical use of Benadryl (diphenhydramine hydrochloride) in 2665 patients are shown in the accompanying table.

The efficacy of this new antihistaminic is also attested to in over 150 reports published in the medical literature.

ELIXIR
10 mg. in each teaspoonful, in pints and gallons.

CAPSULES
25 mg. each, in bottles of 100 and 1000.

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THERAPEUTIC RESULTS WITH BENADRYL IN 2665 PATIENTS

Clinical Entity	Patients	Satisfactory	Questionable	No Benefit	% Showing Improvement
URTICARIA	766	692	16	58	90.3
VASOMOTOR RHINITIS	349	268	2	79	76.7
ECZEMA	128	79	7	42	61.7
HAY FEVER	425	350	36	39	82.4
ASTHMA	435	275	7	153	63.2
MIGRAINE	73	48	1	24	65.7
ANGIONEUROTIC EDEMA	54	46	1	7	85.2
ATOPIC DERMATITIS	66	42	1	23	63.6
PRURITUS	24	18		6	75.0
ERYTHEMA MULTIFORME	28	22		6	78.6
DERMOGRAPHIA	20	15		5	75.0
FOOD ALLERGY	37	32		5	86.5
CONTACT DERMATITIS	63	49		14	77.7
PHYSICAL ALLERGY	11	7		4	63.6
REACTIONS—ANTIBIOTIC	84	81	1	2	96.4
REACTIONS—DRUGS	46	42		4	91.3
REACTIONS—BIOLOGICS	12	12			100.0
DYSMENORRHEA*	44	38		6	86.3
TOTALS	2665	2116	72	478	79.39

*those cases due to histamine-induced spasm of smooth muscle.

Benadryl
hydrochloride

MEDICAMENTA VERA PD & CO.

PARKE, DAVIS & COMPANY, DETROIT 32, MICHIGAN

(Continued from Page 746)

PUBLIC TOO SINUS-MINDED

The public is "overly sinus-conscious," Dr. Albert C. Furstenberg, University of Michigan Medical School dean, told the 15th annual Adult Education Institute.

"Only one person in fifty who diagnoses his own case as sinus trouble really has the condition," he declared.

Dr. Furstenberg pointed out that few cases of heart trouble, arthritis or other systematic diseases are traceable to a sinus.

He warned against use of home preparations.—*Detroit Free Press,* May 15, 1947.

MICHIGAN MEDICAL SERVICE BENEFITS

Beginning May 1, 1947, Michigan Medical Service has been paying $100.00 for appendectomies. This is the last major surgery rate to be equalized with prevailing rates in practice. Several rates have recently been raised, but this is the most outstanding. Obstetrics for direct pay members has been re-established, as noted recently. It was re-established before the expiration date in the notice of suspension, so members are losing nothing, there being no lap.

Under contract with the Veterans Administration, Michigan Medical Service through the doctors of Michigan has been giving authorized medical service to veterans. When the service has been rendered, and reported to MMS the Veterans Administration is billed for the service, plus a small administrative fee. Remittances were promised promptly, but as of May 1, the amount receivable for Michigan Medical Service was $341,000.-00, and for Michigan Hospital Service, $170,000.00. The government owes the Michigan Blue Cross plans over half a million dollars for services to veterans authorized and paid for by the plans, and the government gets the use of this money without interest. This has been the experience since the plan was first put into effect.

BOND-A-MONTH PLAN

The doctor of medicine is supposed to be a good scientist, diagnostician, a good doctor for the ills of the people but a very bad doctor for the financial future. We have received two communications from the Treasury Department, submitting a long article for publication in The Journal, telling of the need of the doctor for some systematic saving system, which will relieve him of the necessity of following financial and other reports and watching the market so as to make an occasional thousand dollars in order that some day in the future he may send Johnnie to college.

We are relieving our readers of four pages of material and condensing the plan. Until now, systematic savings bonds were available only through payroll deductions, but now—

"The depositor who wishes to buy a bond each month signs a card authorizing the bank to deduct the purchase price from his checking account. The bank issues the bonds and delivers them to the customer monthly. The periodic bank statement shows payment for the bonds.

"And from the first and the only time the doctor signs his authorization card, he has nothing else to do except open the envelopes the bank sends him with the bonds inside.

"Incomes of physicians are much more responsive to fluctuations in national income than other professions. The doctor has no social security or pension to fall back upon. He needs simplicity of program, not continued checking, manipulating, buying, selling. There is no safer investment in the world than Savings Bonds."

If you invest monthly under the Bond-a-Month Plan	In five years you will have	In ten years you will have
$ 37.50	$ 2,319.00	$ 4,998.00
75.00	4,638.00	9,996.00
150.00	9,276.00	19,992.00
300.00	18,552.00	39,984.00

CONFERENCE, GRADUATE AND POSTGRADUATE MEDICAL EDUCATION

The University of Michigan Medical School, sponsored by the W. K. Kellogg Foundation of Battle Creek, conducted a conference on Graduate and Postgraduate Medical Education at the Rackham Building, Ann Arbor, May 19, 20 and 21, 1947. The program consisted of six conferences:

1. Review of Graduate and Postgraduate Activities. Moderator, Harold S. Diehl, Minnesota. Discussants, C. E. de la Chapelle, NY University, Wilburt C. Davison, Duke, William A. O'Brien, Minnesota, John B. Truslow, Columbia and R. Hugh Wood, Emory.

2. Graduate Training and Continued Education of the General Practitioner. Moderator, A. C. Furstenberg, Michigan. Discussants, Walter A. Bloedorn, George Washington, Ward Darly, Colorado, E. M. MacEwen, Iowa, William A. O'Brien, Minnesota.

3. Review of Graduate and Postgraduate Activities. Moderator, Joseph C. Hinsey, Cornell. Discussants, C. F. Wilkinson, Michigan, Murray C. Brown, Meharry, Robert A. Moore, Washington, Thomas M. Perry, George Washington, John E. Deitrick, Cornell, Charles N. Holman, Oregon.

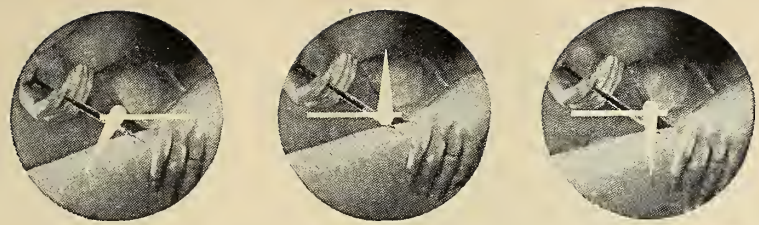
4. The Teaching of the Basic Sciences. Moderator, Curruer McEwen, New York. Discussants, Thomas M. Perry, George Washington, Ford K. Hick, Illinois, John E. Deitrick, Cornell, C. E. de la Chapelle, New York.

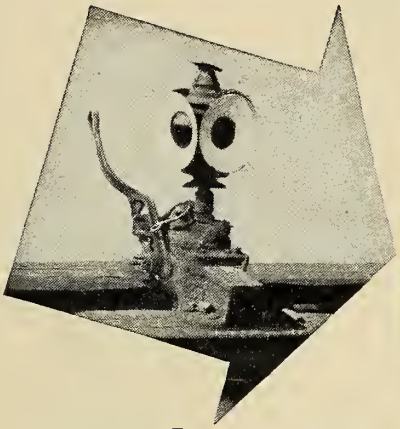
5. Review of Graduate and Postgraduate Activities. Moderator, Howard H. Cummings, Michigan. Discussants, Ford K. Hick, Illinois, Robert P. McCombs, Tufts, John T. McClintock, Iowa, James P. Baker, Virginia, Ward Darley, Colorado.

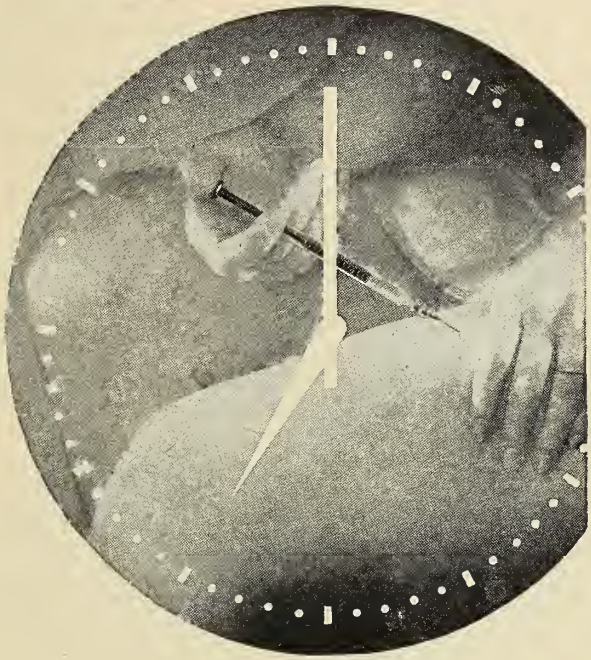
6. The Regionalization of Medical Education. Moderator, Samuel Proger, Tufts. Discussants, Lester J. Evans, Commonwealth Fund. W. T. Sanger, Virginia, Charles F. Wilkinson, Jr., Michigan. Each of these conferences was followed by extensive discussion.

On May 20, the evening dinner was addressed by Vice President Adams of the University, and by Salvador Zubiran, Rector of The National University of Mexico who spoke on "Graduate Education at the National University of Mexico." He told of the building of a new university in a new city, and gave pictures. Ralph A. Sawyer, Dean of the Graduate School, University. of Michigan, who headed the scientific work of the atom

(Continued on Page 750)







a switch in time

A SWITCH to 'Wellcome' Globin Insulin with Zinc can often save the annoyance of a second or third daily insulin injection—for in many cases the patient's needs can be supplied with *only one injection a day* of this unique intermediate-acting insulin. Three distinct steps provide the welcomed change-over:

1. THE INITIAL CHANGE-OVER DOSAGE: The first day, 30 minutes or more before breakfast, give a single dose of Globin Insulin, equal to ½ the total previous daily dose of protamine zinc insulin or of protamine zinc insulin combined with regular insulin. The next day, dose may be increased to ⅔ former total.

2. ADJUSTMENT TO 24-HOUR CONTROL: Gradually adjust the Globin Insulin dosage to provide 24-hour control as evidenced by a fasting blood sugar level of less than 150 mgm. or sugar-free urine in the fasting sample.

3. ADJUSTMENT OF DIET: Simultaneously adjust carbohydrate distribution of diet to balance insulin activity; initially 2/10, 4/10 and 4/10. Any midafternoon hypoglycemia may usually be offset by 10 to 20 grams carbohydrate at 3 to 4 p.m. Base final carbohydrate adjustment on fractional urinalyses.

Most mild and many moderately severe cases may be controlled by *one daily injection of 'Wellcome' Globin Insulin with Zinc.* Vials of 10 cc.; 40 and 80 units per cc. Developed in The Wellcome Research Laboratories, Tuckahoe, New York. U.S. Pat. 2,161,198. Literature on request.

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CONFERENCE GRADUATE AND POSTGRADUATE MEDICAL EDUCATION

(Continued from Page 748)

research and study, gave a most interesting talk on the work of the Navy in which he served. He presented moving pictures of the "Operation Crossroads," showing the enormous preparations and carrying out of the two atom blasts at Bikini, one in the air and one under water.

Participants in Conference

SALVADOR ZUBIRAN, *Rector,* The National University of Mexico, *Director,* Hospital for Nutritional Diseases
JAMES P. BAKER, *Director of Continuation Education,* Medical College of Virginia
WALTER A. BLOEDORN, *Dean, School of Medicine,* The George Washington University
MERL CARSON, *Assistant Dean in Charge of Postgraduate Affairs,* Washington University School of Medicine
M. DON CLAWSON, *President,* Meharry Medical College
HOWARD H. CUMMINGS, *Chairman, Postgraduate Medical Education,* University of Michigan Medical School
WARD DARLEY, *Dean,* University of Colorado School of Medicine
WILBURT C. DAVISON, *Dean,* Duke University School of Medicine
JOHN E. DEITRICK, *Director of Postgraduate Instruction,* Cornell University Medical College
C. E. DE LA CHAPELLE, *Associate Dean; Director, Postgraduate Division,* College of Medicine, New York University
HAROLD S. DIEHL, *Dean of The Medical Sciences,* The Medical School, University of Minnesota
LESTER J. EVANS, The Commonwealth Fund
A. C. FURSTENBERG, *Dean,* University of Michigan Medical School
HANCE F. HANEY, *Head of Department of Physiology,* University of Oregon Medical School
FORD K. HICK, *Assistant Dean in Charge of Postgraduate Instruction,* University of Illinois College of Medicine
JOSEPH C. HINSEY, *Dean,* Cornell University Medical College
CHARLES N. HOLMAN, *Medical Director,* University of Oregon Medical School
FRODE JENSEN, *Director of Graduate and Postgraduate Training,* University of Colorado School of Medicine
E. M. MACEWEN, *Dean, College of Medicine,* The State University of Iowa
JOHN T. MCCLINTOCK, *Director of Postgraduate Education,* College of Medicine, The State University of Iowa
ROBERT P. MCCOMBS, *Director, Postgraduate Teaching,* Tufts College Medical School
CURRIER MCEWEN, *Dean, College of Medicine,* New York University
ROBERT A. MOORE, *Dean,* Washington University School of Medicine
WILLIAM A. O'BRIEN, *Director, Postgraduate Medical Education,* The Medical School, University of Minnesota
THOMAS M. PEERY, *Director, Postgraduate Instruction,* School of Medicine, The George Washington University
SAMUEL PROGER, *Professor of Clinical Medicine,* Tufts College Medical School and Medical Director, Pratt Diagnostic Hospital
W. T. SANGER, *President,* Medical College of Virginia
TRAWICK H. STUBBS, *Associate Dean,* Emory University School of Medicine
GRANT TAYLOR, *Assistant Dean,* Duke University School of Medicine
JOHN B. TRUSLOW, *Assistant Dean, College of Physicians and Surgeons,* Columbia University
CHARLES F. WILKINSON, JR., *Co-ordinator, Graduate Medical Education,* University of Michigan Medical School
R. HUGH WOOD, *Dean,* Emory University School of Medicine
GRAHAM DAVIS, President Elect, American Hospital Association, and Kellogg Foundation, Battle Creek.

William A. Hyland, president of the Michigan State Medical Society, and the Editor also attended, as well as about a dozen others not registered.

MICHIGAN UNIFORM FEE SCHEDULE FOR GOVERNMENTAL AGENCIES

A letter from the Department of Social Welfare extends the application of the Uniform Fee Schedule to still another agency. Ophthalmologists have been treating clients of the Aid to the Blind and Division of Services for the Blind in the State Department of Social Welfare. Until October, 1944, this consisted simply of examinations to determine eligibility to receive service. Since that time services have been extended to include medical diagnosis, medical and surgical treatment, guidance, and counseling, training and job placement for those who desired to become employable.

Eye examinations are authorized routinely for every "blind" client who comes to the department for service. The purposes of these examinations are as follows:

1. To determine degree of visual defect.
2. To determine possibility of improving vision by means of medical or surgical care, or correcting lenses.
3. To provide basic information to assist the department in helping the client to decide on a vocational objective.
4. To establish a basis for relief statistics of blindness.

The Department may pay a rate which is no higher than the doctor's fee to any other public agency for the same service. It may, further, be no higher than his private patient rate. The doctor may use the Michigan Uniform Fee Schedule for Governmental Agencies as a guide, up to a ceiling of $75.00.

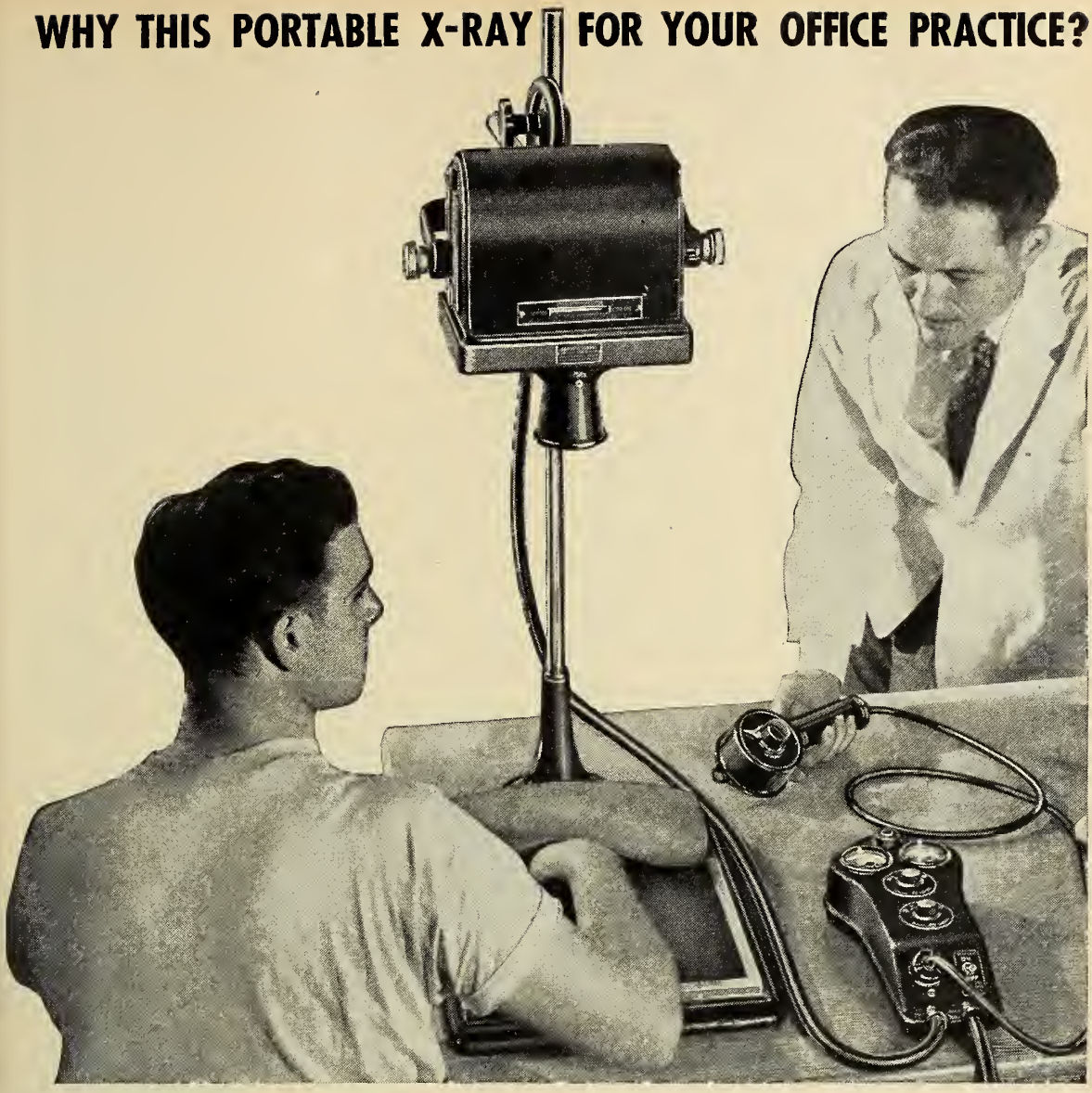
This information is quoted from a letter sent to ophthalmologists on the department list.

ANOTHER PEARL HARBOR?

The Territory of Hawaii presented a serious threat for the introduction of socialized medicine, for three months, ending only with the adjournment of the Legislature on May 3. Had this legislation been enacted, it would have introduced in the United States a precedent with far-reaching implications and results—especially since Hawaii is moving toward statehood.

Based on a "Hospital Services Study Commission" report, two compulsory sickness insurance bills were introduced into the Legislature. In order to defeat the two proposals, the Territorial Medical Association engaged in a very intensive public relations program. The compulsory sickness tax bill failed to get out of committee, despite the efforts of various social workers and other proponents, including Nathan Sinai, Dr. P.H. of Ann Arbor, Michigan.

WHY THIS PORTABLE X-RAY FOR YOUR OFFICE PRACTICE?



The fact that thousands of physicians are today using G-E X-Ray's *Model F Portable* is perhaps the most convincing evidence of its recognized value.

You too, would soon conclude that for office x-ray examinations, the *Model F Portable* atop your desk or table greatly simplifies matters; also that the inambulant patient is grateful for this service right in his home.

Within the practical range of service for which this unit is intended, the quality of radiographs it is capable of producing is second to none, regardless of price. You'll also appreciate the high standard of workmanship throughout.

The moderate investment required, and the potential value of a *Model F* in your practice, assuredly justify your investigation. Mail this coupon today.

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GENERAL ELECTRIC X-RAY CORPORATION

333 Years of Medical Partnerships

By Henry C. Black and Allison E. Skaggs

Battle Creek, Michigan

"THE ADVANTAGES of a partnership are much more apparent than its disadvantages, and fortunately most of the disadvantages may be eliminated by a thorough understanding of them and proper arrangements made at the start." This quotation from an article we wrote for this JOURNAL[5] ten years ago is as true now as it was then. Several years later we wrote briefly, discussing "Assistants—Associates—Partners,"[2] outlining distinguishing characteristics of each type of association. Since that time frequent inquiries have indicated the interest being shown in medical partnerships and one need for more factual information. As a basis for this analysis, we have selected from our list of clients fifty small Michigan partnerships limited to two or three physicians.

Small groups such as this seem to be more common in Michigan than large ones although there are a number of groups which jointly own a building but practice separately. Several physicians may rent space individually from a common landlord, perhaps himself a physician, and the group may call itself the Dr. Blank Medical Group or the Blank Clinic, but few of these associations actually pool income and investment on a partnership basis. In the states surrounding Michigan, however, many large groups have been operating as partnerships for years. Why MSMS members have seen fit to prefer small partnerships is a matter for conjecture; certainly we would not venture an explanation. In any event, our experience with these larger groups has little bearing on our analysis of the smaller ones, and the problems of group practice do not properly come within the scope of this discussion.

Here are a few statistics about the fifty partnerships used in making our observations, most of which we insisted in organizing, all of which were clients of ours the first of this year, and had been regular clients for a variable period, averaging over three years. Thus our information is based on actual experience and not on an accumulation of figures from less accurate sources. The average age of these partnerships was 3.7 years; sixteen were in existence for from five to sixteen years, twenty-five from one to five years, and nine were started during 1946. Distribution as to locality was quite representative—several in Detroit, many in other cities and some in small communities.

Eighteen of the partnerships did general practice, while the other thirty-two limited their practices to one or more specialties. Strangely enough, however, only two practiced two different specialties within the same partnership (Medicine and Surgery), and in the thirty others the partners limited themselves to one specialty.

As to investment, further analysis shows that thirty-one shared ownership of the partnership assets equally, regardless of the method used to distribute profit. Only twenty-two divided profits equally, but nineteen others were working toward equal division, with the percentages changing from year to year. Nine partnerships based the division of profits in whole or in part on the volume of income each partner produced.

Before going into the specific recommendations which we feel are possible, it becomes necessary to explode two theories commonly entertained by physicians and their advisors; first, that the overhead in a partnership is less; and second, that the sharing of equipment, furniture, et cetera, results in a smaller investment per man. *We find neither of these assumptions to be true.* In a comparison of costs of practice for the years 1939,[1,3] 1944,[4] and more recently 1946, it was found that the incomes, expenses, and investment per man varied in each of these years only because of changing economic conditions, and no differences of as much as 1 per cent could be found between the averages of individuals practicing alone and averages taken from partnerships divided by the number of partners represented.

We have pointed out repeatedly the importance of using adequate legal counsel in the preparation of sound partnership agreements and the extreme importance of good financial records.[6,7] The legal instrument should include, among other things, duration, ownership, distribution of profits, definition of expenses, and dissolution in the event of death or disagreement. In the case of Junior-Senior relationships, it is well to include any rights the Senior might retain as to control of policy. Beyond this, any specific detail which the partners

(Continued on Page 754)

Experience is the Best Teacher

Yes, experience is the best teacher in smoking too!

IT WAS their experience during the wartime shortage of cigarettes which taught people the big differences in cigarette quality. People smoked many different brands then—whatever brand was available. And so many more smokers came to prefer Camels as a result of that experience that now more people are smoking Camels than ever before. However, no matter how great the demand, *we don't tamper with Camel quality. Only choice tobaccos, properly aged, and blended in the time-honored Camel way, are used in Camels.*

According to a recent Nationwide survey:

MORE DOCTORS SMOKE CAMELS

than any other cigarette

R. J. Reynolds Tobacco Company, Winston-Salem, N. C.

(Continued from Page 752)

care to include is permissible and often advisable, but in general simplicity is to be preferred to ambiguity, and a partnership is successful NOT because every possible detail is covered under the terms of a contract, but rather because the partners are compatible, have mutual confidence in each other, and use reasonable judgment in their business decisions.

The books of financial record should be set up by an accountant competent in the technical details of partnership accounting and familiar with the problems peculiar to medical practice. As we pointed out years ago, good financial records are most important in any practice, and a necessity where the income and investment of several partners are involved. Likewise the termination of a partnership upon the death of a partner, or because of the inability of the partners to get along, requires financial records sufficient to permit an orderly liquidation by a third party who may have only records on which to rely.

A sound financial position is always desirable in a partnership because "our" money and not "my" money is involved, and there have been too many cases in which depreciation reserves were divided as income, with a resulting lack of funds for replacement. This common error prompts us to urge that all partnerships use occasional accounting counsel to see that their records reflect the conditions they believe to be true.

Obviously some partnerships should not begin distributing profits on an equal basis. For instance, when a physician with an established practice takes in a younger man, or when there is a substantial difference in age, training or experience, it is necessary to use a graduated percentage working toward but not necessarily arriving at an equal distribution in future years. Generally speaking, if the investment is equal even from the beginning of the partnership, it simplifies the bookkeeping and tends to stabilize the younger man. If the junior partner does not have enough money to "buy in," the senior partner can take his note, but actually paying for it as it becomes possible gives the junior partner a far better evaluation of the cost of his interest in the partnership.

When a partnership is formed among physicians, any of whom have uncollected accounts on their books, the question often arises as to whether they should be included in the partnership income as they are paid (perhaps adjusting percentages to compensate), or whether they should be collected by the individual doctor. In either case, good accounting is essential, and it may be done either way satisfactorily. Although too involved to discuss in detail here, sometimes there are tax advantages to a partnership through beginning and closing its books on other than a calendar year basis, in which case no previously earned receivables should be included with partnership receipts, unless the individual doctor gets and reports that income separately. Several other items require special treatment, such as the drugs and supplies already charged off as expenses by the individual, and used by the partnership after its formation.

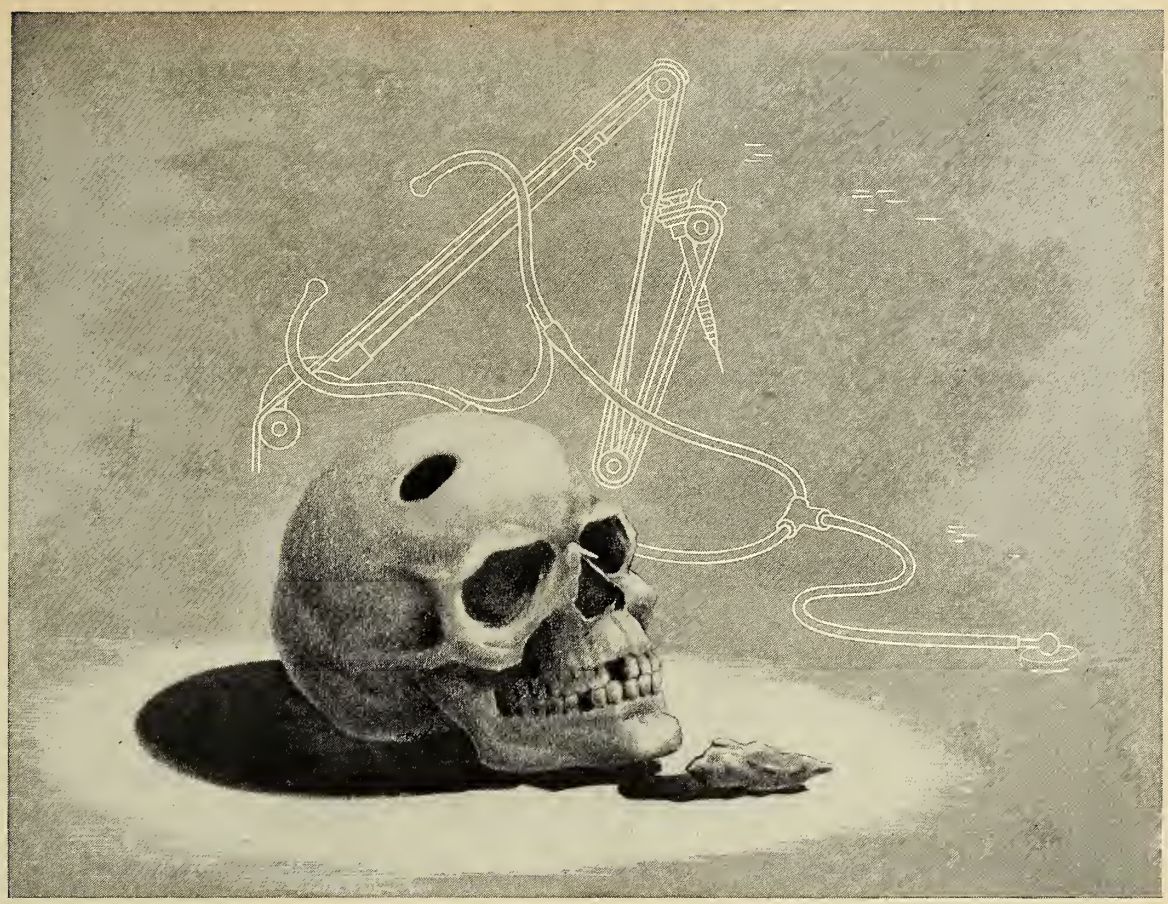
Anyone who contemplates association with a partnership should know the other partners well, both professionally and socially, be familiar with their abilities, habits and ambitions, so that compatability and mutual interests are reasonably assured. If a young man is being considered as a candidate for a partnership, it is far better for him, as well as for the others involved, to consider his temporary employment long enough for all to qualify each other as a partner before an actual contract is drawn. The termination resulting from failure to get along under this arrangement is very simple as compared with the dissolution of a partnership, which at best is involved and sometimes even requires litigation.

Conclusion

Our experience during the past fifteen years has shown us enough advantages in partnership practice to outweigh the disadvantages, provided proper precautions are taken before and during the lifetime of the partnership. The leisure not readily available otherwise; the counsel a partner can obtain from his associates; the frequent availability of better clinical facilities; the continuity of service to patients during absences; and, last but not least, the improved financial security—all of these are possible. The degree of their attainment is in proportion to the ethics, confidence and enthusiasm contributed by each partner.

Bibliography

1. Black, Henry C., and Skaggs, Allison E.: A study of incomes and expenses for 1939. J. Michigan M. Soc., (Sept.) 1940.
2. Black, Henry C., and Skaggs, Allison E.: Assistants-associates-partners. J. Michigan M. Soc., (July) 1940.
3. Black, Henry C., and Skaggs, Allison E.: Budgets. J. Michigan M. Soc., (June) 1938.
4. Black, Henry C., and Skaggs, Allison E.: Medical incomes in wartime. J. Michigan M. Soc., (July) 1945.
5. Black, Henry C., and Skaggs, Allison E.: Partnerships. J. Michigan M. Soc., (Dec.) 1937.
6. Black, Henry C., and Skaggs, Allison E.: The investment program. J. Michigan M. Soc. (July) 1937.
7. Black, Henry C., and Skaggs, Allison E.: What you owe and what you own. J. Michigan M. Soc., (Mar.) 1937.



The First Operation....

The First Surgical Operation was performed with a sharp stone and firebrand in Neolithic Egypt. A skull was pierced to let out evil spirits. The patient survived. Modern trephining was on the way.

The First Dental Operation, in the era of the Pharaohs, was extraction by an instrument shaped like a goat's foot. Replacements were of wood, ivory, metal buttons and ox teeth. Modern dentures were on the way. But the modern concept of the doctor's *responsibility*, as set forth in malpractice law, was *not* yet on the way.

A First Operation Today is wisely avoided by most doctors until they have secured their Medical Protective policy—providing, as it does, *complete* coverage and *confidential* preventive counsel.

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National Health Bill

Statement by E. F. Sladek, M.D., Traverse City, Michigan
Chairman of the Council, Michigan State Medical Society
Secretary, National Conference on Medical Service

I feel that the ideology on which S-545 is based is sound; that it is a good bill. Should this bill become law, the health of our people can be materially benefited.

The efficacy of any national medical care program can be judged only by its value at the local level.

I speak from the local level, as I have spent twenty-seven years in the practice of medicine in Traverse City, Michigan, which has a population of 15,000 and serves a rural area having an additional 10,000 population. This region is typical of those areas in the United States which are removed from the immediate influence of great urban centers.

Advantages of the National Health Bill of 1947

1. It Continues and Encourages Voluntary Prepaid Medical Care Plans

In areas such as my 25,000 population county, the operation of a voluntary pre-payment medical care plan has, over the past few years, resulted in the correction of many long-standing disabling defects among the people and has made a major contribution to the health of the entire population. S-545 favors a continued development and encouragement of such voluntary pre-paid medical care plans. This is a highly desirable feature of any national health plan, as it permits people having a relatively small income to budget their funds to defray the cost of unforseeable illnesses, accidents and surgical repair.

2. Care is Adequate Under Voluntary Prepaid Medical Care Plans

The care given under voluntary pre-paid medical care plans is adequate to meet the needs of the people. In my locality, it has been demonstrated repeatedly that those who carry such protection need not and do not worry about receiving care for any illness which would seriously impair the health of the person or his ability to make a living. I must qualify this by saying that this does not provide for care in extended illnesses such as tuberculosis or infantile paralysis and such disabling disease. However, those afflicted with such diseases are being cared for under state and national programs of both a governmental and non-governmental variety. I refer to such programs as the Vocational Rehabilitation Service, the Tuberculosis Commissions and Associations, the National Infantile Paralysis Association and so forth. Under S-545 all medical services by governmental agencies will be under one directive head and consequently, because of a more uniform type of service, these patients can be more efficiently covered and served.

This protection provides care for the great majority of cases which physicians on the average meet in their daily practice, and thus the great majority of illnesses confronting the people. These contracts do not provide for preventive medicine. To do so would be unnecessary duplication for preventive medicine from the state level is being taken care of most adequately by the state departments of health, medical societies, various educational organizations and departments. On the local level, preventive medicine is not sufficiently expensive to be of great concern since it consists mainly of inexpensive regular physical checkups and a knowledge of healthful living. I repeat when the voluntary medical care program can be placed within the reach of all who desire it, the health of the people insofar as medical care is concerned will be adequate.

3. Desirable to the Patient

From the standpoint of the patient, the care given under voluntary pre-paid medical care plans is the most desirable of any variety. Under these plans the patient-physician relationship is maintained; the facilities of the best institutions are available; the stigma, if such exists, of charity is not present; red tape is cut to an absolute minimum; the care of the patient is given by physicians of the patient's choice; delay in the administering of medical care in emergency cases is unnecessary.

(Continued on Page 758)

THERE ARE THOSE *in every field of endeavor who tower above others by unswerving adherence to a policy founded on high principles.*

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THE HARROWER LABORATORY is pledged to serve the best interests of public health and the allied professions of medicine and pharmacy. The guiding principles of the Harrower policy are:

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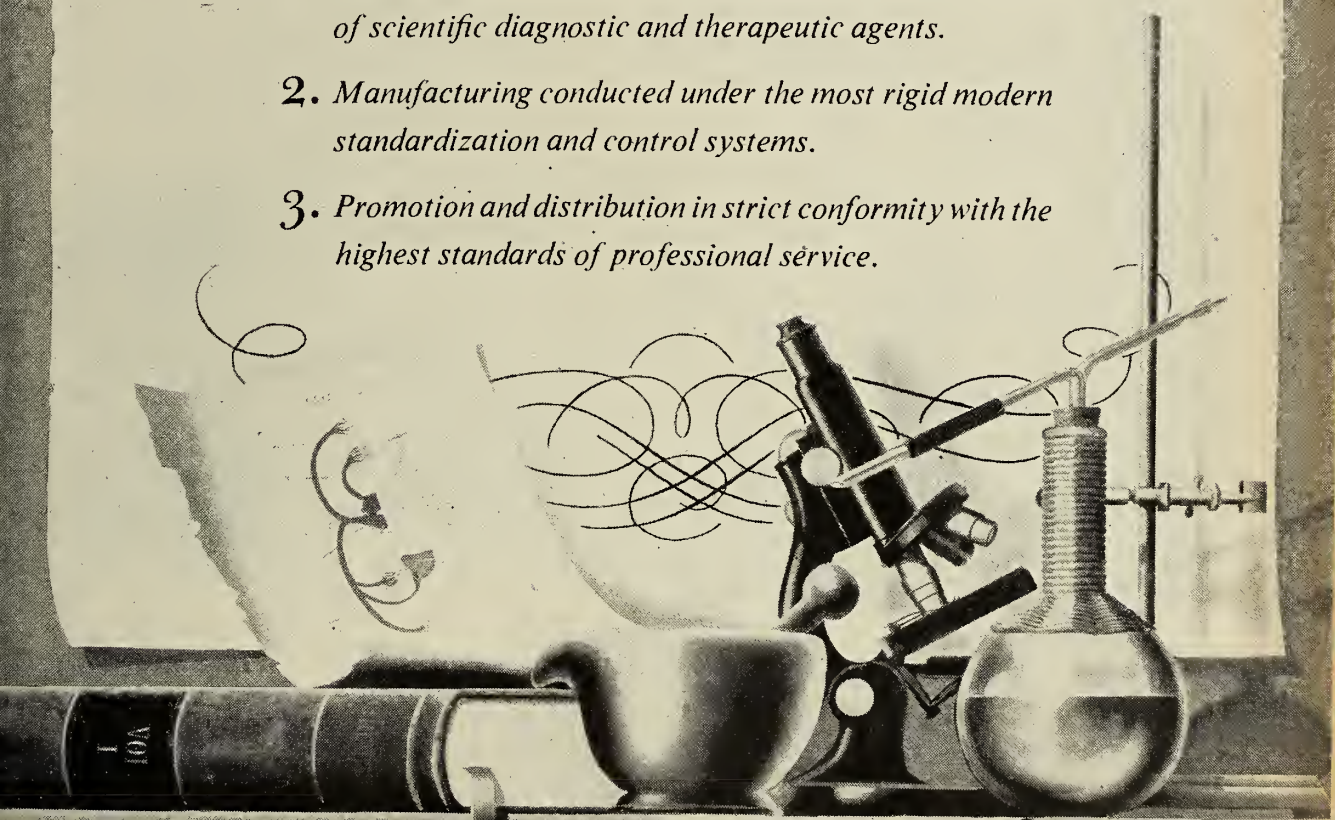

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"Serving the Profession in a Professional Manner"

(Continued from Page 756)

4. Satisfactory to the Doctor

Voluntary pre-paid medical care plans are satisfactory from the standpoint of the doctor. It provides him with adequate recompense for his services so that he can locate in any area in which there is adequate demand for a doctor and thus provides a means for the proper and adequate distribution of medical care to all areas. He feels confident in the administration of such plans for representatives of his own profession, elected by him, serve in administrative and in advisory capacities on the governing boards. By daily experience, he is familiar with the procedures, forms and implementations. He feels he is carrying on the traditions developed under the private practice of medicine which have proved to be most capable of advancing the standards of his profession.

A classic example of how the voluntary pre-paid medical care plan can be adopted to care for the medically indigent is supplied by the "home town" plan for the care of veterans now being carried on in Michigan under Michigan Medical Service. The type of co-operation which may be expected from doctors under such a plan is evidenced by the fact that while no veteran has been given less than adequate and proper care, nevertheless only 60 per cent of the authorizations for care granted by the Veterans Administration have been used by our Michigan doctors of medicine. Example: a veteran is allowed ten treatments for his particular illness; the doctor who would have been paid for ten treatments finds the patient needs but six treatments to effect a cure; the government has been spared the cost of the additional four treatments. This record indicates that the doctors far from being greedy as is occasionally charged have given veterans the best care they knew with results beneficial both to the patient and to the government. That is the kind of co-operation that can be expected from a voluntary medical care program in which the medical profession has confidence.

5. It Would Enlarge Coverage of Voluntary Medical Care Plan to Include the Medically Indigent

The value of such plans is not disputed. It is only their limited coverage which seems at fault. S-545 is a remedial measure which will go far to extend the coverage of these plans so that any person who so desires can receive their benefits. In others words, it will provide coverage for that income group known as the medically indigent—those who can provide themselves and their families with the basic necessities of life, i.e., food, clothing and shelter, but may not be able to protect themselves financially against unpredictable illness. This group represents a good percentage of the people of such an area as Traverse City. By the extension of such coverage as is given by voluntary pre-paid medical care plans to the medically indigent, S-545 will render a second great service.

Service Can Be All-inclusive

If particular groups are included under the Taft-Ball-Smith-Donnell Bill, such as clients of old age assistance, aid to dependent children clients, welfare clients and others now being cared for under other government plans, the voluntary group medical care plans can include them, similar to the manner in which they have accommodated the Veterans Administration and its great pressing problem—a plan which works equally as well in my community of 25,000 population as in the largest cities of the state.

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Tablets of 2.5 mg. . . . . bottles of 20 and 100.
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Tablets of 0.625 mg. . . . . bottles of 100 and 1000.
Liquid, containing 0.625 mg. in each 4 cc. (1 teaspoonful)—bottles of 120 cc.

While sodium estrone sulfate is the principal estrogen in "Premarin," other equine estrogens . . . estradiol, equilin, equilenin, hippulin . . . are also present as water soluble sulfates. The water solubility of conjugated estrogens (equine) permits rapid absorption from the gastrointestinal tract.

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Highlights of State Health Legislation, 1947

The few bills listed below are highlights of some 60 bills in the 1947 Legislature which dealt directly with or touched the practice of medicine. Report on all measures will be published in the August JMSMS.

The following bills were passed by the Michigan Legislature of 1947:

H.B. 451. This Act will implement in Michigan the provisions of the Federal Hospital Survey and Construction Act. As passed, the law is almost verbatim with the recommendations made by the MSMS Executive Committee of The Council. It calls for a Director to be appointed by the Governor to administer the act with the help of an Advisory Council. No crippling amendments were included in the bill as finally passed in spite of sundry attempts of a cultist organization to use it as an opening wedge for entrance into medical hospitals. The Act specifically provides against any attempt to use the provisions of the law to socialize medicine. Much of the credit for passage of this Act is due Representative Howard Estes of Birmingham, the introducer of the bill.

S.B. 274, 275. As passed these Acts will raise per-diem hospital rates under the Afflicted and Crippled Children's Acts to $11 and the maximum surgical fee in the Michigan Crippled Children Commission fee schedule to $90, a 20 per cent increase. (See You and Your Business, page 746)

S.B. 201. As passed this law will license and regulate vivisection. No damaging amendments were made to the bill as originally drafted, despite bitter activity by antivivisectionists aided by the vigorous promotions of a chain—newspaper.

S.B. 378. This Act will require immunization against diphtheria, whooping cough and smallpox as a condition precedent to entrance in school.

The following bills failed of passage:

S.B. 215. This bill would have permitted osteopaths to certify for the commitment of the insane to mental disease hospitals. It was passed by the Senate, but died in a House Committee despite extreme attempts of the osteopaths to make it a law.

H.B. 404. If passed, this proposal would have excepted the chiropractors from the provisions of the Basic Science Law.

H.B. 405. This bill would have recognized naturopaths as a profession by licensing and regulation.

H.B. 166. Would have provided for licensing of industrial medical assistants, thus dignifying factory first-aiders with professional status.

H.B. 416. Would have regulated and controlled the sale of pets. This was an antivivisectionists' bill.

H.B. 495. If passed, this legislation would have prohibited vivisection and the sale of animals for vivisection purposes.

H.B. 439. Would have limited Blue Cross Plans to participating hospitals only and limited cash awards to the return of one year's premium. It was reported from Committee to the House floor, but after a heavy skirmish was referred back to Committee.

HEALTH PROPAGANDA PROBE DEMANDED

Free Press Wire Services

WASHINGTON, July 3, 1947.—A House expenditures committee has asked the Justice Department to proceed against six Federal agencies to stop what the committee called illegal expenditures on "propaganda" to influence Congress.

The propaganda program, the committee charged in a report, was designed to build up public demand for enactment of the Wagner-Murray-Dingell bill providing compulsory health insurance.

The committee said key personnel in the agencies planned to set up "health workshops" in strategic areas, for the purpose "of propagandizing farm and labor leaders to build up an artificial, federally-stimulated, public demand" for the legislation.

Citing a law against use of Federal funds for the purpose of influencing legislation, the committee named as "known to have participated in this campaign" the United States Public Health Service, the Children's Bureau, the Office of Education, the United States Employment Service, Agriculture Department and the Bureau of Research and Statistics of the Social Security Board.

The committee said the evidence indicated that workshops, held in Saint Paul, Minn., and Jamestown, N. D., were planned, conducted, and largely financed with Federal funds.

It added that pamphlets and propaganda material were prepared to be distributed under the imprint of the CIO.

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Michigan Rural Health Conference

September 18-19, 1947

The first statewide Rural Health Conference in Michigan will be held at Michigan State College, Thursday and Friday, September 18-19, under the sponsorship of the Michigan State Medical Society with the co-operation of twenty-five other state organizations interested in rural health. H. B. Zemmer, M.D., Lapeer, has been named Chairman and Hugh W. Brenneman, Lansing, Secretary of the Conference.

The purpose of the Conference is to explore the needs and problems of health in rural areas. A constructive statewide rural health program and a stimulus to action are expected to result from the deliberations.

This meeting is the result of joint action by the Rural Medical Service Committee and the Public Relations Committee of MSMS. It is an implementation of Organizational plans of the MSMS Public Relations Plan which calls for "activity in connection with other Michigan groups interested in medical care and health."

Members of the Committee on Arrangements for the Conference are: H. B. Zemmer, M.D., Lapeer, Michigan State Medical Society; J. K. Altland, M.D., Lansing, Michigan Department of Health; W. G. Armstrong, Niles, Michigan State Grange; R. J. Baldwin, East Lansing, Michigan State College; C. L. Brody, Lansing, Michigan Farm Bureau; Mildred Cardwell, Lansing, Michigan State Nurses Association; Graham Davis, Battle Creek, W. K. Kellogg Foundation; Carleton Dean, M.D., Michigan Crippled Children Commission; Ira Dean, Grand Rapids, Michigan Association of Welfare Boards and Board of Supervisors; Milon Grinnell, East Lansing, Michigan Farmer; A. J. Phillips, Lansing, Michigan Education Association; R. W. Tenny, East Lansing, Michigan State College.

Among co-operating organizations are: Michigan State College; Michigan Education Association; Michigan Foundation for Medical and Health Education; Michigan State Grange; Michigan Farm Bureau; Michigan State Social Welfare Commission; Wayne University Medical College; Michigan Department of Health; Ingham County Medical Society; Michigan Medical Service; Michigan State Nurses Association; Michigan Tuberculosis Association; Michigan Hospital Service; W. K. Kellogg Foundation; Michigan State Pharmaceutical Association; Michigan State Medical Society Women's Auxiliary; Michigan Hospital Association; Michigan Society for Crippled Children and Disabled Adults; American Cancer Society, Michigan Division; Michigan Crippled Children's Commission; Michigan Farmer; Michigan Junior Farm Bureau; Michigan Health Council.

The Program of the First Annual Michigan Rural Health Conference will be published in the August Number, JMSMS.

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119 SCIENTIFIC AND TECHNICAL DISPLAYS

At the 82nd Annual Session of the Michigan State Medical Society, scheduled for Grand Rapids, September 23-26, 1947, 119 interesting and instructive exhibits will be located in the Exhibit Hall of the Civic Auditorium. They will remain open for your inspection from Tuesday noon until 5:00 p.m. on Tuesday, Wednesday and Thursday; and until 11:30 a.m. on Friday. Two hundred and seventy-seven demonstrators will man these exhibits, for the convenience of the estimated 1,800 physicians who will attend the MSMS convention.

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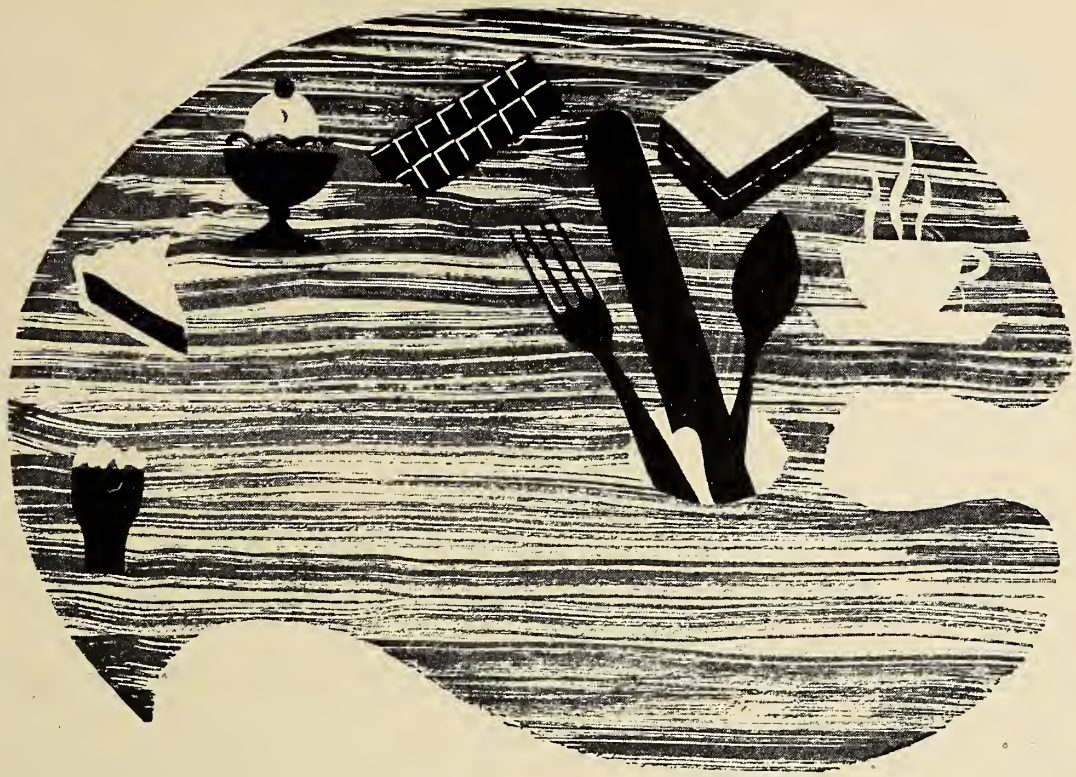

the art of eating

Too many people "seem to feel that the art of eating consists of filling the stomach to capacity three times a day."[1] They ignore the fact that "calories alone do not make a balanced diet."[1] They need, therefore, and will continue to need, support of vitamin supplements. To better reconcile the science of nutrition with the "art of eating," Upjohn provides a full range of potent, balanced vitamin preparations. In a variety of dosage forms, Upjohn vitamins help paint a better nutritional picture for all age groups by obviating deficiencies or providing for their treatment in the practice of medicine and surgery.

1. J. South Carolina M. Assn. 52:186 (July) 1946.

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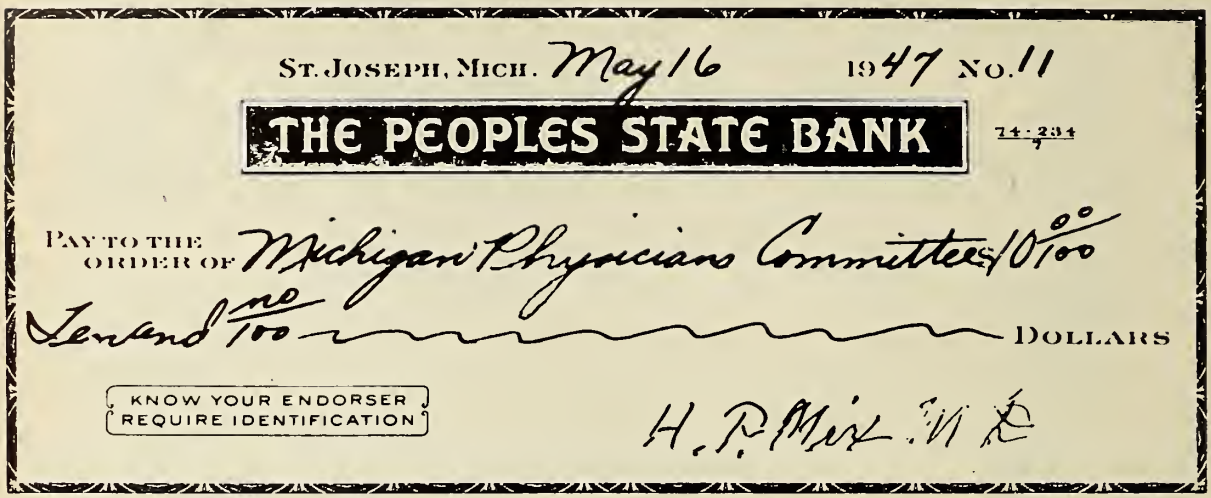
SOCIALIZED MEDICINE CAMPAIGN

An appeal was made by the Michigan Physicians Committee for help in carrying on their work. Response has come generally from the state but one outstanding contribution has appeared.

Such willingness to support a program that from the very nature of things cannot long benefit the donor bespeaks a generosity and enthusiasm that is truly worth commendation. We are glad to publish Dr. Mix's letter and a photostat of his check, which we hope and believe the officials returned with heartfelt thanks.


St. Joseph, Mich. May 16 1947 No. 11

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H. P. Mix M.D.

Dr. Witwer, Secretary-Treasurer, writes:

I am enclosing herewith a letter, together with a check, from Doctor H. P. Mix, of Riverside, Michigan. While I think we all appreciate the splendid sentiment expressed in this venerable gentleman's letter, I personally do not feel that I would care to assume the responsibility of accepting or rejecting this check; but, my opinion is that a man who has reached this age should not be expected to make any sacrifice, which is what this contribution probably represents; but I shall abide by your decision, whatever it may be.

Riverside, Michigan

Dr. E. R. Witwer
Dear Doctor:

Would like to make remittance more but owing to reduced income and continued outgo, cannot spare more. My age, 96 coming October, see Medical Journal 1946, "State's oldest physician," is allowing very few medical fees at the present.

Wishing you best of luck for your fight for Doctor's rights, I am fraternally yours,

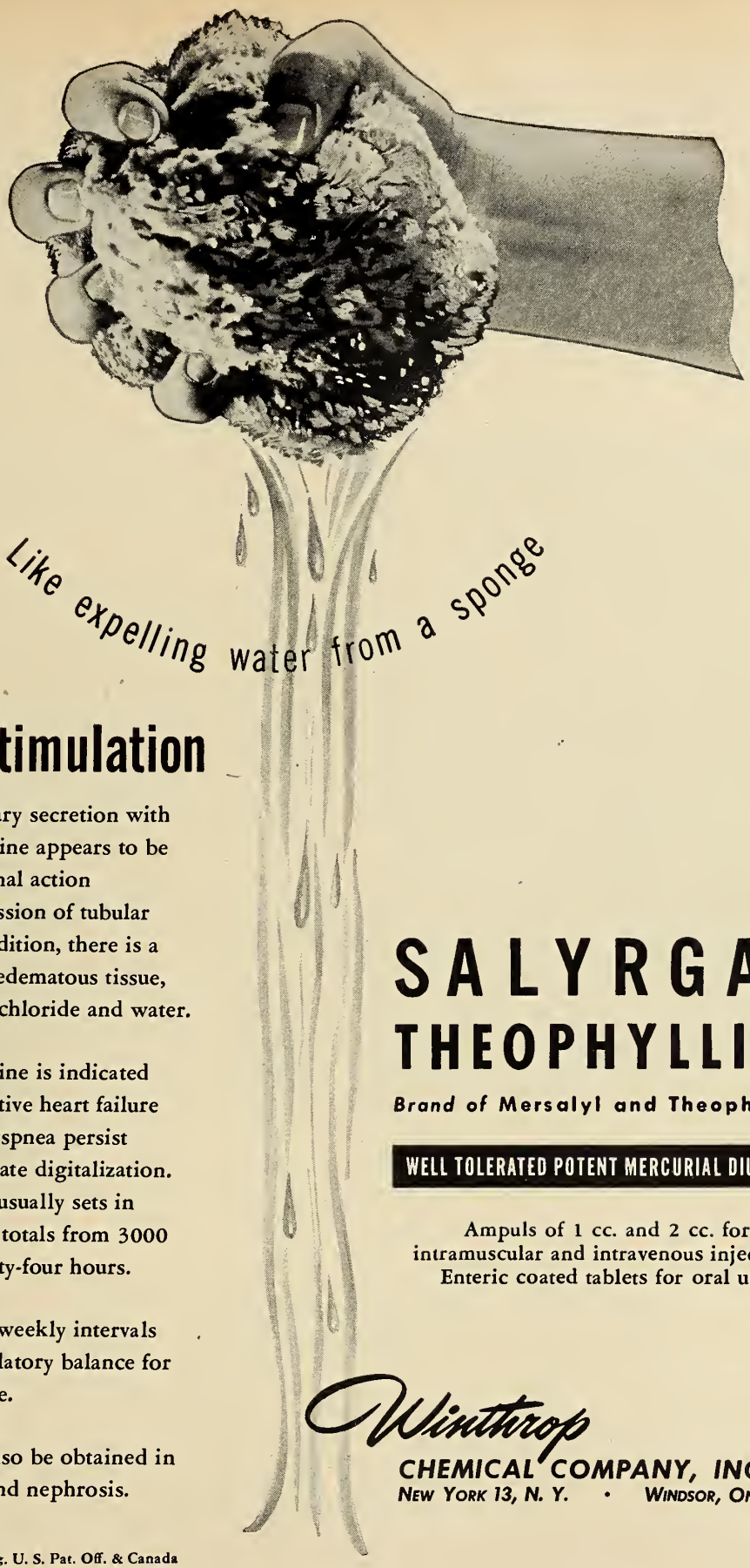
H. P. Mix, M.D.

PEDIATRIC CONSULTANTS

The Michigan State Medical Society is sponsoring a program of postgraduate education in pediatrics in cooperation with the Michigan Department of Health and the Departments of Pediatrics and Postgraduate Medicine of the University of Michigan.

William J. Morrow, M.D. and James C. Beesley, M.D., who have appointments on the staffs of the Pediatrics Department of the University of Michigan and the Bureau of Maternal and Child Health of the Michigan Department of Health, are the pediatric consultants in this program. These men will alternate for periods of four months at the University of Michigan and in the field. At the University of Michigan they will conduct short postgraduate courses in pediatrics, and in the field they will be available for pediatric consultant services to physicians. The field work began July 22 in Midland County and extended into the counties of Gratiot, Isabella, Clare, Manistee-Benzie, and Wexford, ending August 29.

The postgraduate courses in pediatrics at Ann Arbor will be of two weeks' duration and will be conducted for physicians in groups of three or four. Physicians will pay for their own maintenance in Ann Arbor, but there will be no charge for tuition. Physicians who wish to make applications to take short courses in pediatrics should write to the Committee on Postgraduate Education, Michigan State Medical Society, Room 2040, University Hospital, Ann Arbor, Michigan. Requests for field services of the consultants should be made to the Bureau of Maternal and Child Health, Michigan Department of Health.



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Stimulation of urinary secretion with Salyrgan-Theophylline appears to be due chiefly to its renal action consisting of depression of tubular reabsorption. In addition, there is a direct influence on edematous tissue, mobilizing sodium chloride and water.

Salyrgan-Theophylline is indicated primarily in congestive heart failure when edema and dyspnea persist after rest and adequate digitalization. Gratifying diuresis usually sets in promptly and often totals from 3000 to 4000 cc. in twenty-four hours.

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Good results may also be obtained in chronic nephritis and nephrosis.

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Premedical Education

For some years it has seemed desirable to provide an opportunity for teachers of premedical students to meet with medical educators and admission committees to discuss problems of mutual interest. Accordingly, Alpha Epsilon Delta, national honorary premedical fraternity, sponsored such a conference at the University of Louisville on February 21 and 22, 1947. The conference was attended by representatives of nine medical schools and nearly seventy undergraduate colleges and universities in the five-state area of Ohio, Indiana, Michigan, Illinois, and Kentucky.

The conference comprised two main sessions: One dealing with problems of the natural sciences in premedical and medical education and the other dealing with the problems in the social sciences and humanities in relationship to premedical and medical education. The first session was keynoted by a paper by Dr. John L. Caughey, Jr., Assistant Dean of the School of Medicine of Western Reserve University. This was followed by nearly three hours of discussion from the floor. The second session was similarly led off by a paper by Dr. Paul F. Bloomhardt, Professor of Biography, Wittenberg College. This also was followed by more than two hours of floor discussion. The dinner meeting on the evening of February 21 was addressed by Father Hunter Guthrie, Dean of the Graduate School of Georgetown University. His subject was "The Need for Liberal Arts in a Premedical Education."

Deep interest and concern was evidenced regarding the methods, content and direction of current premedical and medical education. There was almost unanimous agreement that we have tended to overemphasize the science content of premedical education to the neglect of the social sciences and humanities. It was evident that there is much concern with the state of our society, with recognition of the tremendous social turmoil, the instability and indecision that characterize the present. It was felt that the medical profession, both in its educational processes and in practice, must become more cognizant of and responsible for the social ills that beset us. The plea was voiced by all the medical educators present for men and women of high character, ideals, social consciousness and conscience, maturity and stability to deal with the problems of our society.

There was complete agreement among both premedical and medical teachers that students preparing for the study of medicine should be thoroughly grounded in the fundamentals of physics, chemistry and biology required for admission to medical school but no more; and that they should be encouraged—and even required—to take more courses in the social sciences and humanities. All agreed that piling up credits in science far beyond those required for admission was undesirable and to be discouraged. It was recommended that students take the full four-year liberal arts course leading to a bachelor's degree with about 50 semester hours in the natural sciences and the remaining 70 to 80 hours in the social sciences and humanities. It was urged that statements to that effect be included in the bulletins of the medical schools and suggested that such statements be solicited by the sponsors of this conference for that purpose.

Many medical educators feel that foreign language requirements for admission to medicine should be dropped. At the same time, it was felt that foreign languages should be retained in the college degree programs as a part of the liberal education the degree should imply. It was suggested that so far as the medical schools are concerned Greek and/or Latin might well be used to satisfy the language requirements in the colleges as these languages provide a more useful basis for scientific and medical terminology than modern languages do.

It was generally stated to be the practice of admitting officers to select their freshman students on the basis of three factors: first, an estimate of general scholastic ability and performance, as a working rule requiring about "B" averages for acceptance; second, personal qualifications, including character, social personality and emotional stability as indicated by interviews by the admission committee and recommendations of premedical educators; and third, the results of the Aptitude Test and in some cases the Graduate Record Examination.

The moral and religious aspect of education was presented in Father Guthrie's paper. His remarks produced a strong impression on the group, indicative of the growing concern for the problems we face in that area of education.

Altogether, the conference was unusually well received and all attending appreciated the fact that the program included all three aspects of education—the natural sciences, the social sciences and humanities, and the moral and religious. A complete report, including the papers and discussion, appears in the May issue of *The Scalpel,* official magazine of the fraternity.

Hugh E. Setterfield,
National President, Alpha Epsilon Delta

EXTENDED SERVICES MMS

Periodically it has been proposed by groups of doctors that Michigan Medical Service extend its coverage to operations in the home and office, in order to relieve the tension on the hospital beds, and to make more services available to subscribers. This has not been feasible, but at the last meeting of the Board it was voted to take certain selected groups and make available certain specified services to be performed outside of the hospital. These are services now scheduled for twenty dollars or over. This is an experimental program to determine costs and feasibility, and is limited as to groups, services, and time.

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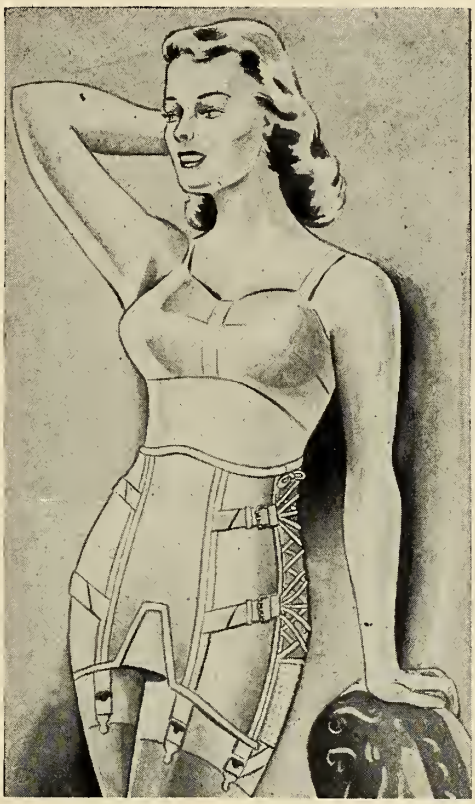

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START HEALTH INSURANCE PLAN, TRUMAN ASKS

Washington, May 19 (AP)—President Truman asked congress today to make at least a start at this session on a national health insurance program.

Some senators already are preparing legislation. But with the Republican leadership planning on a July 31 adjournment and much business still remaining, prospects for the health program appeared uncertain.

Mr. Truman's message, completed at Grandview, Mo., over the week end and sent to the Capitol today urged "a national health insurance program" which would provide money to all persons covered by it for two purposes:

1. To pay their necessary hospital, doctor bills and dentist bills.

2. To reimburse them, at least in part, for earnings lost by "illness or disability" not connected with their work.

Leaves Details to Congress

The message indicated that the President wants all men, women, and children in the country to be assured of "needed medical attention" by the insurance plan. But he left to congress the details as to just who would pay the premiums, and how much should be contributed directly by those paying the premiums and how much by the federal treasury.

When the President first presented his recommendations to congress in 1945, the White House called the plan a "compulsory" system in which all wage earners would be required to participate, as they must now in the social security program.

The word "compulsory" did not appear in today's message, although reference was made to the 1945 proposals. And today's paper said that the program should be one by which "all people who are covered by it" would have their necessary medical expenses paid.

Taft Favors Volunteer Plan

Sen. Taft (R., O.), among other congressional leaders, favors a voluntary health insurance plan, in which citizens would be free to participate or not as they choose. He also wants emphasis on local administration.

Mr. Truman wrote that "a national health insurance plan can and should provide for administration through state and local agencies, subject only to reasonable national standards."

The 1945 message declared that "this is not socialized medicine," in reply to opposition arguments advanced earlier on that angle. Today's message contained no direct allusion to that argument, but it asserted that:

"Under the program which I have proposed, patients can and will be as free to select their own doctors as they are today. Doctors and hospitals can and will be free to participate or to reject participation."

Urges Other Projects

The chief executive also called anew for congress to set the federal government at work on three other matters he recommended in 1945. These are to provide:

"1. Adequate public health services, including an expanded maternal and child health program.

"2. Additional medical research and medical education.

"3. More hospitals and more doctors—in all areas of the country where they are needed.

"I am pleased to observe that important advances were made by the last congress toward realization of some of the goals which I set forth in my earlier message," Mr. Truman wrote. "But we must not rest until we have achieved all our objectives. I urge this congress to enact additional legislation to authorize the program I have outlined, even though the fulfillment of some aspects of it may take time."

Greatest National Resource

The President declared at the outset:

"Healthy citizens constitute our greatest national resource. In time of peace, as in time of war, our ultimate strength stems from the vigor of our people. The welfare and security of our nation demand that the opportunity for good health be made available to all, regardless of residence, race, or economic status."

His earlier message recalled that 5 million men, one-third of those examined, were rejected in the draft.—*Chicago Tribune,* May 20, 1947.

OPPOSITION IN 1934; SUPPORT IN 1947!

Nathan Sinai, Dr.P.H., Ann Arbor, subscribed to the following statement in the report to the MSMS House of Delegates in April, 1934, re his study of health insurance in England in connection with the proposed "Mutual Health Service," under consideration at that time:

> "In presenting this report your commission wishes to *record its opposition to the introduction into the United States of any system of health insurance now existing in any country in Europe.* No system conforms at present with all the policies adopted by the Michigan House of Delegates in July, 1933.
>
> These policies are:
>
> 1. Free choice of physician by the insured.
> 2. Limitation of benefits to those of medical service.
> 3. The control of medical service benefits by the profession.
> 4. The exclusion of individuals or organizations that might engage in health insurance for profit."
>
> *(The italics are ours.*—Ed.)

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Development and Use of the Psychiatric Out-Patient Department

By Arthur H. Ruggles, M.D.
Providence, Rhode Island

THE NEED for preventive psychiatry has long been recognized, but received its greatest impulse during World War II and the postwar period following.

I am sure we all agree that one of the very best services in preventive medicine is the adequate out-patient department. My remarks will be confined to the neuropsychiatric clinic, but many of the inferences may well be applied to other specialties.

In the field of the neuroses, early out-patient treatment is generally accepted to mean the attempt to prevent chronicity and hospitalization, with their attendant costs in time, money, personal happiness, social and economic dislocation. But to my mind, it means more than that. It means on the positive side, an opportunity to help people to function more effectively, live more fully, get a perspective on themselves and their situation. Like Chinese doctors, I visualize the job of the neuropsychiatric clinic of the future as primarily to keep so-called normal people well and happy, by giving them an understanding of themselves and the meaning of their behavior, by seeing them through crises, which might swamp them unassisted, or lay a pattern of defeat, (as is possible, under given circumstances, with any one of us here in this room), and by helping them to realize their potentialities and accept their limitations.

One of the great therapeutic advantages of out-patient care, especially in the field of emotional maladjustments, is that during treatment the patient is usually able to remain at work (clinics should provide at least one opportunity for evening appointments) and live at home (provided the home environment is good); so that he has the security of a job, the help of his family, and can work through his difficulties and practice his newly won attitudes in his normal surroundings, as might not be possible in the more artificial environment of a hospital.

In the past, many of our out-patient departments have been organized and conducted on an antiquated basis, being dependent on the *voluntary* services of the out-patient staff. This was based on the old idea of the apparenticeship system, which held that the young physician must gain his experiences via the OPD route without remuneration. As someone once put it (I am afraid with a good deal of justification), "The poor are God's greatest gift to the interne."

Under this system, the young physician struggling to make a living, necessarily cut the out-patient corners, if he could see a paying patient before he reported to the clinic, or by leaving the clinic early in order to keep an appointment at his office. There was seldom adequate time for careful investigation and treatment of cases. Patients would come in at 9 o'clock in the morning, perhaps to be seen only at noon. In the meantime, they sat huddled on the benches, irritated or dispirited by the monotonous waiting, regaling each other with their manifold symptoms; until it

Presented at the Eighty-first Annual Session of the Michigan State Medical Society at Detroit, Michigan, September 26, 1946.

was not uncommon that a neurotic, by the time he saw the doctor, had added to his original symptoms several more which he had acquired from his fellow sufferers.

When the patient's turn finally came, examination too often was cursory. His physical complaints were often discounted as neurotic imaginings, and insufficient medical investigation made. Social investigation, in the sense we know it today, with the emphasis on the individual and his environment, was almost non-existent; concern being centered, usually, on the economic status of the patient's family and their sources of income. The patient-load per doctor was heavy. It was not uncommon for a physician to try to see five new cases and twenty old cases in a single brief morning. In the parlance of the soldier, many patients inevitably got the "brushoff." The last patient seen, all too often was only asked, "What do you complain of?" The hurried answer most frequently was insomnia, nervousness and lack of appetite. The doctor's response, "I'll give you prescription No. 17. Take a teaspoonful three times a day and come back in three weeks, if you do not feel better." When the patient did return, it sometimes happened that he saw a different doctor, the first doctor having served his period.

Under these circumstances, it is understandable that the patient's condition often remained undiagnosed and was therefore inadequately treated—if this procedure can be dignified by the term "treatment." Equally important, the patient himself keenly felt the superficiality of this approach, resented being treated as a number, and had little confidence in the therapeutic effects of the prescription or the advice handed out to him. The resistance of a considerable number of veterans to OPD community clinics is, in my opinion, largely to be attributed to the impression created by these "charity clinics" of old.

Against this out-dated organization, what is our concept of a model neuropsychiatric out-patient clinic today? Most of us have certain ideas about it; much has been written and theorized about it; but when we look about us there appears, in actual practice, to be a good deal of divergence with regard to the organization and operation, and even orientation, of existing psychiatric clinics. In short this may be attributed to the shortage of trained personnel, resulting in unavoidable compromises under pressure of necessity. But even more, it would seem to be due to a lack of a clear concept as to what constitutes *adequate* out-patient care. The truth is, we are on the threshold of a new era in psychiatry, with the major concentration on the nervous and emotional difficulties of normal individuals in their daily living, rather than the abnormal, requiring custodial care. The experience of the Army and the Navy during the war pointed this out: most of the work of the military psychiatrist was concerned with keeping personnel on the job or returning them after brief hospitalization, to their posts; only a small fraction of their time was devoted to psychotic patients. The same swing is taking place in civilian psychiatry. Yet in the department of out-patient treatment, we are without the orientation and pattern we have developed over the years for in-patient care. We still have to clarify our therapeutic goals more specifically, to establish more clearly our criteria for referral, to determine what is the most efficient organization, the most effective procedure and the estimated cost of qualified out-patient care. This can only be acquired on the basis of factual data, gathered at the source. Military experience has given us a fine start, but it was a specialized situation; we have a growing group of able young psychiatrists trained in psychotherapy or in training; and we have a growing number of highly qualified mental hygiene clinics blazing the way for what the modern neuropsychiatric out-patient department should ideally be.

On the basis of our experience at Butler Hospital —albeit our Out-patient Service has been in operation only nine months—and of my own contact with war psychiatry, I propose to outline what to me seem some of the significant characteristics of a clinic offering *adequate* psychotherapy. We do not presume, at Butler Hospital, to have all the answers; we ourselves are still groping; but we have, from the beginning, considered our out-patient clinic as a therapeutic research project and to this end have kept more exhaustive and detailed records than ordinarily indicated.

In the first place, it clearly appears that adequate out-patient treatment necessitates a *full-time paid medical staff,* as against the old system of voluntary service. The staff should be organized as a team, consisting of psychiatrist, clinical psychologist, psychiatric social worker and psychiatric nurse. The number of representatives from each of these professions will be determined by the

case-load. Ideally, it seems to me that there should be one psychiatrist for every two new patients and three old patients seen in the morning, or evening. The psychiatrist in charge of the clinic must be thoroughly versed not only in modern psychotherapy, but in good medical practice; he should have an apprenticeship in a mental hygiene clinic, a wide experience with and understanding of normal behavior and the departure from it. Needless to say, the other members of the team should also have a thorough understanding of the modern principles of dynamic psychiatry. The dearth of professional personnel at the present time, makes it impossible sometimes to assemble a team, every member of which is fully trained and experienced; hence the importance of a supplemental training program conducted by means of regularly scheduled staff conferences. The staff conferences, of course, are vitally important for therapeutic reasons; it is here the Chief brings together all the findings, defines procedures aimed at the effective integration of the various departments of the clinic, and heads up the treatment program.

In the second place, instead of the system of gathering large groups of neuropsychiatric patients together often for hours at a time, there should be a *strict appointment system.* No new patient should be given an appointment of less than one hour for the first visit, and follow-up visits should average at least one-half hour each. Not only should patients be seen only by appointment, but they should be seen promptly when they appear for their appointments. This is especially important with patients with neurotic conditions, where anxiety and exaggerated feelings of self abasement so often play a part.

Thirdly, the importance of *comprehensiveness and thoroughness of examination* cannot be overemphasized. Every patient should be given a complete physical and neurological evaluation of structural and physiological aberations. At Butler, all laboratory and medical facilities of the hospital and its consultants are drawn upon. This may mean a consultation with the gastroenterologist, or with the laryngologist, or with the otologist, as well as with other specialists. Reports of these specialists are made in writing and included in the final résumé of the case by the psychiatrist in charge of it. As general medical men, you will be interested to learn how fully this consideration of the organic aspects has justified itself in our experience. In about one-third of the cases seen, previously unrecognized or insufficiently treated physical conditions were discovered, which were basic to the patient's "nervous" condition, or had a direct bearing on it; such as a case of Hodgkin's Disease, tuberculosis and several cases of severe malnutrition.

The psychiatric examination may precede, follow or be interspersed with the physical examinations and tests. There is no set sequence at our clinic. The order depends somewhat on the availability of the various staff members and specialists; but primarily it is determined by the mood and concern of the patient himself. If he has a great need to unload, the psychiatrist may let him unburden himself and just talk uninterruptedly and unhurriedly for the first two hours. If, on the other hand, his anxiety centers on the "pains in his chest," it may be that a physical examination and possibly an x-ray would relieve his mind most. If his primary concern is his fitness to do a certain job or his desire to enter another field, it may be that he will first be sent to the psychologist for vocational aptitude tests.

The psychiatric examination includes history taking, psychological tests (including the projection techniques, such as Rorschach and Thematic A perception) and the first exploratory interviews with the psychiatrist (sometimes aided by pentathol). In our experience, we have found that eight hours is required on the average for history taking, complete physical examination and such psychological and laboratory tests as are indicated. The number of preliminary interviews with the psychiatrist will vary with the individual case. Actually, as with all other investigations, examination is a part of treatment, and there is no fine line that can be drawn between them. Indeed, the thoroughness of the examination, to a great extent, lays the foundation for the confidence of the patient in the treatment.

Definite treatment can only proceed on the basis of such careful studies. It is only when all the evidence is in, that the patient gradually emerges as an individual, not as a "case" of insomnia, or depression, or anxiety, but as Jimmy Jones, with his unique constitutional make-up and experiences, his personal motivations, his own family and work situation, whose symptoms may mean one thing to him and quite a different thing to another patient. This seeing of the patient in-the-round, as it were, is the very crux of mod-

ern psychotherapy. It takes time, patience, and an orientation keenly sensitive to the law of individual differences.

The number of treatment interviews that follow again will depend upon the individual and his needs. It may be that he only needs re-direction and re-orientation and that a few talks will straighten him out. It may be that deep therapy is indicated, requiring treatment over a considerable period. In any event, it is understandable, that once having formed his bond of confidence in his particular psychiatrist, it is this psychiatrist and no other, in whom he will have faith to continue treatment. Hence, *continuity of treatment* is another criterion I should like set up.

In addition to the treatment interviews with the psychiatrist, it may be that the patient will want to see the psychologist again, as his insight grows and he wishes to get a realistic picture of his capabilities. It may be that a visit of the psychiatric social worker to the home of the patient will be indicated, or that the patient's family will come for an interview with her, so that they too may grow in understanding and become an active part of the team. It may be that the patient will take part in the occupational therapy program conducted by the hospital for its in-patients—which we have found a valuable adjunct in some instances also for patients under out-patient treatment.

While the out-patient service at Butler was set up as a community clinic, the veteran case-load has been given priority, and has thus far absorbed most of the staff. From the period of January 1 to August 31 of this year, one hundred and forty-one patients made one thousand forty-two visits. The average number of visits was seven per patient. During the same period, thirty-five patients were discontinued for a variety of reasons. Thirty-eight were discharged as substantially recovered and sixty-eight were still under treatment at the end of August. Ninety-two of these patients were diagnosed as psychoneurosis, five as psychosis and forty-four as various other psychosomatic or organic disorders.

As I have previously stated, an average of eight hours is consumed on history taking, physical examination and psychological and laboratory tests. These eight hours are usually not considered as eight visits. Often three or four hours may be consumed in history taking and physical examination and be counted as one visit. I want to make it clear that we cannot generalize too much, as our whole tendency is to individualize, but you will see that the figures stated of one hundred forty-one patients making one thousand forty-two visits, bringing the average number of visits per patient up to seven, would be misleading if I gave you the impression that each hour counted as one visit.

The results of such comprehensiveness, both of examination and treatment, summed up in the words of the Chief of our Out-patient Service, Dr. David G. Wright, may be; "there seems to be no doubt that the patients in general are strongly supported by, and very much appreciate, the attitude of the Out-patient Service, with its continuous emphasis on the most thorough investigation possible and the expenditure of whatever time is necessary to work through both the primarily somatic and primarily psychic aspects of the illness involved. An aspect of medical care for which the typical patient has felt, and has had, a great need, would appear to be that of being treated as a whole. He is a total organism complete with a body, thoughts, feelings and attitudes, inseparable from the environment in which he is functioning, and it would appear that he must be treated as such. In general, the patients have appeared to be most co-operative, appreciative and gratified by the treatment they received, whether or not speedy symptomatic improvement has taken place. Except in isolated cases, very few appointments have been broken without notice and without later communication from the patient in explanation. Where the patient terminated the treatment himself, it was usually for good reasons."

What are some of the comments of the patients themselves, as made to the members of the clinic's staff, or as we hear them from the doctors, the referring agencies, or their families? In their own words, what is it the patients say?

"There's no waiting around there; you just come in for your appointment and they see you right away. . . . They really *listen* to your story, and don't hurry you. . . . They tell you *everything* you feel or think is important. . . . I've had a buzzing in my ears for years . . . or a pain in my back . . . but the doctors always said it was imagination . . . I never could get them really to check it . . . but here they gave me the works, inside and out and when they couldn't find anything, I was satisfied, maybe it was in my mind. . . . They treat you like

you were a human being. . . . it's the first time in my life I think a doctor really looked at me and tried to understand how it felt to be *me* going through what I was."

Let me submit: what, in the final analysis, is the best criterion of the adequacy of treatment? Results count, and, as in business, it is the satisfied customer whose opinion is the crucial one. It does not matter if we, professionally, feel the patient's condition is improved, if he does not feel much better himself; it does not matter if we have examined him to our professional satisfaction, if he thinks we have ignored or overlooked what *he* feels is important to his condition. The soundest basis for successful therapy is the patient's conviction that everything possible has been done for him, *his* confidence in and appreciation of the clinic's service. And, as in business, it is *his* opinion of out-patient treatment that will "advertise" the product and "sell" it, far more effectively than any program of public education. The cloud of distrust, fear and stigma, which has too long darkened mental conditions and their treatment, will only be dispelled as the word spreads, from one satisfied patient to another: "you should go up there, they really helped me. It would be good for *anyone,* just to get a better idea of themselves, whether they are in trouble or not."—Two cases may illustrate types of patients with whom we are dealing.—

Two questions of special interest to you, I shall just briefly touch on. One is the question of cost of treatment.

It is very difficult to get an accurate cost accounting of such treatment, but our best estimate, which we feel is undoubtedly a low one, is that the cost per visit is $8.65.

This may seem to be an expensive type of treatment, but if large numbers in the community can, by this preventive service, be given efficiency on the job and be comfortable in their inter-personal relationship for approximately $100.00, it is indeed a low financial expenditure. Especially in contrast to that necessitated by leaving the job and having weeks or months or perhaps permanent hospital treatment. We feel that in providing care for veterans, the medical profession must determine what adequate out-patient treatment is, and that the government must be prepared to pay for such adequate care, in service-connected cases, the cost of which may seem very great at the moment, but we believe that by such adequate care, a large amount of the tax payers' money can be saved for the future.

The other question that may be in your minds is: Whom should you refer for psychiatric out-patient treatment? By what indications shall you decide that here is a man who complains of insomnia, whom you yourself, with your intimate knowledge of the patient and his family situation and his confidence in you as his family doctor, can probably help; and here is another, with a similar complaint, yet who should have specialized treatment? This is no easy question to answer in an hour or in a book, let alone in a few sentences. For it depends, of course, on the individual case. When pressed for a brief guide that will be practical and yet not too limiting, however, I have submitted two general criteria: one is the *disruptive effect* of the symptom, the other its *duration.* If you have a patient who is suffering with insomnia or nervous headaches to such an extent that his work is seriously affected or his home life jeopardized, and if this condition has *continued without improvement* over a period of time—let me say, for three or four weeks—despite efforts to help him, I would say that such a patient should be referred for psychiatric attention.

Case Record

Case 1.—Patient, S. W., aged twenty-five, single, unemployed at time of referral. Twenty-three visits over a seven-month period. Previous to Army service extremely out-going, active, competitive, social, and having a consistently good work record.

Brought up from earliest infancy by a sister twenty years his senior, married and unable to have children of her own. An unusually strong affection and identification with his sister-mother. Combat infantryman with ten months front-line combat in Italy with every man in his platoon a casualty. He, himself, wounded by sniper fire and evacuated because of wounds. Considerable portion of muscles of the right thigh destroyed and one testicle shot off. Appropriate tension during combat, present symptoms developing only after hospitalization for wounds.

Present symptoms, nausea, gastric distress, extreme irritability, depression, complete inability to associate with people or enjoy former interests. No significant physical findings. No significant laboratory abnormalities, x-ray of the chest and gastrointestinal series well within normal limits. Rorschach and TAT tests indicate average intelligence with functional impairment including constriction, stereotypy and lack of ability to establish normal relationship with people; feelings of anxiety and inadequacy indicated. Anxiety apparently tied up with own sexual organs and battle experiences. TAT content evidencing immaturity and great need for help.

The patient spent the first few hours airing resentment and disgust at his previous treatment by doctors and their treatment of his sister who at present is suffering parallel symptoms.

With the aeration, aggressive feelings became translated more and more into increased tension and activity to the degree that he impulsively hit a man sitting behind him in a movie because of annoyance at this man's noisy shifting about in his seat. Following this, the relationship of guilt feelings to hostility was discussed and intravenous sodium pentothal was begun. Under pentothal, without any suggestion by the therapist, tremendous abreaction of feelings of aggression and guilt took place. In the first pentothal interviews patient simply lived through traumatic experiences, particularly of his being wounded and his feeling responsible for the death of a friend and his knifing German outposts in the dark; having amnesia and an inability to synthesize these matters on his emergence from the effects of the drug.

At this point he developed red spotty dermatitis of the hands and of the wrists. Allergy skin test was negative. After further acceptance of his feelings of guilt under pentothal, three months after beginning of treatment, in which he frequently used the phrase "their blood on my hands," red spots on hands cleared up and the patient lost gastric symptoms, tension and fears, and began work. Insight increased with further pentothal interviews and the patient, himself, connected guilt feelings with castration fears as appropriate punishment. By six months after beginning treatment, the patient was entirely asymptomatic for a period of a month at a time, with very brief slip-backs into depression, capable of reversal by a single interview.

The patient is now engaged to be married, is busy with all his old interests and is working steadily.

Case 2.—Patient J. W., aged twenty-eight, single, unemployed at time of referral. Sixteen visits over a four-month period; previous to Army service, consistently good work record; conscientious, rigid with many interests. Family constellations essentially healthy and balanced and supporting. Air-gunner in heavy bombardment, flying out of England over Germany; hit by large fragment of flak on his fourth raid; shot down over Berlin on his fifth raid, damaging back in parachute jump and suffering frostbite of feet; badly beaten about the head by German civilians before being made a prisoner-of-war for twenty months, in the last four months of which prolonged forced march with food at starvation level. At this time feet became flattened and denuded of skin, thighs and buttocks and axilla became covered with dermatitis; teeth and gums began to bleed and to have profuse purulent discharge. On release from prison camp and until first contact with the Clinic no effective medical help had been given.

Present symptoms, depression, almost to the point of confusion; hopelessness; complete inability to be interested in work, play or people; pain in the back, feet, thighs; extreme insomnia and fatigability; anorexia; abdominal pain and griping; continuous foul breath; recurrent thoughts of suicide. He could not eat, sleep, sit, stand, walk or speak with anyone in comfort.

Physical examination consistent with history; blood count showing increased white cells; urine showing albumin, red cells and hyaline casts; sedimentation rate increased; urea nitrogen, variable, rising at times to 37 mg.; chest and abdomen essentially clear by x-ray examination. The electroencephalogram was classified as borderline abnormal with poor regulation and unusual distribution of normal rhythms with, however, no bilateral or localizing differences.

Psychological examinations show Rorschach signs of extreme constriction of the emotional life.

Treatment of physical difficulties by intense vitamin therapy; oral penicillin; arch supports prescribed by the orthopedist; and exercises for increasing the adequacy of the circulation in the feet resulted in the clearing of his mouth, stomach, skin, foot symptoms.

Psychotherapy, with the use of sodium pentothal, resulted in the catharsis of his held-in aggressive feelings and an understanding by the patient of his feelings of guilt and fear which had developed in large measure in relation to certain of his crew members. As the depression began to lift, the patient was started on work in the carpenter shop in the hospital, and within a month was able to return to his old interests and to do part-time work.

Recurrence of several of the symptoms were related in part to flare-ups in the state of the kidney damage which he apparently had. By the end of the four-month period, however, he stated that he was in all ways quite well, working hard every day, fishing and doing all kinds of jobs about the house; he spends most evenings with his girl and has no lack of confidence in his ability to handle a job which he expects shortly to take.

MSMS

STOP—LOOK—LISTEN

STOP telling the patient there is nothing wrong with him but nerves—Don't say: "Go home and forget it."

LOOK for the facts as the patient sees them.

LISTEN attentively to patient's story.

If all persons would respect their nervous systems as they do their teeth, there would soon be as growing an understanding of nervous disorders as there now is of dental conditions.

Let the patient talk—it pays dividends

Placebos are dangerous—for the doctor to use when he doesn't know what else to do.

An ounce of understanding is worth a pound of medication.

Penny-wise and pound-foolish is the doctor who is concerned only with the physical aspects of disease.

Misuse of words may be more dangerous than the misuse of drugs.

—Michigan Mental Hygiene Committee

The Fundus Oculi in Diagnosis and in Prognosis

By Edmund B. Spaeth, M.D.

Philadelphia, Pennsylvania

EACH TIME an ophthalmologist has the privilege of talking before a group of medical men, not limited in their work to his specialty, he hesitates a bit, and shortly decides to "consider the retinal blood vessels." I know this as a fact from former personal experiences, and the literature proves it quite conclusively.

The ophthalmoscope, in medical diagnosis, is probably next in importance to the microscope, though granted a poor second. Further, when one speaks of the ocular fundi, it must be either in terms of vascular pathology, or relative to nerve tissue pathology, for it is these which are significant.

Both ancient and contemporaneous medicine have demonstrated repeatedly ophthalmologists functioning (perhaps masquerading) as internists, and neurologists. The reverse has occurred, but very rarely. It emphasizes rather strongly that early attitude of prewar German medicine, as exemplified by Heine, in considering ophthalmology as a branch of internal medicine. It also calls attention to the dislike various ophthalmologists have registered, and quite properly so, in placing ophthalmology on Undergraduate Medical School Faculties under the direction of the Chief of the Department of Surgery. It is true that ophthalmology has an important surgical side as a specialty, but so also have gastroenterology and neurology. The minutiae of anatomical details necessary to ophthalmic surgery is the only difference between ophthalmology and gastroenterology in their surgical attributes. The ophthalmologist did not steal this surgery from the surgeon, instead, the surgeon released it, gave it up willingly, in fact he sloughed it gladly and with his blessing. One only needs to read the histories of the early ophthalmic surgeons to appreciate this.

One other comment aimed toward the same point stated above: that tremendous amount of work done, in the diagnosis and classification of hypertensive and toxic forms of arteriolar pathology, by ophthalmologists, could have been carried out only by men who were essentially learned physicians in addition to being excellent ophthalmologists.

Look to your medical book salesman for two relatively recent books written by ophthalmologists,[4,18] and a third,[9] in which an ophthalmologist was a most important collaborator, for material in the field of general medicine significant to every branch of medicine. Thirty years ago an ophthalmologist (Leber[8]) gave medicine a monumental work in this field which still continues as the source book for most similar efforts.

When discussing pathology of the ocular fundi one must, of necessity, differentiate between basic pathology of the choroid and the retina, and in turn these two from pathology of the optic nerve, remembering that this nerve consists of the terminal centripetally directed nerve fibers from the retina. By contiguity and continuity of these tissues, pathology in one must of necessity be followed by characteristic pathological changes in the others. In addition, the individual structure controls the type of pathology possible, and at the same time modifies the essential characteristics which develop from similar basic etiological factors.

The choroid is an organ, fundamentally vascular in anatomic characteristics, and from the standpoint of this paper to be concerned with morbidity seen in and transmitted by the blood stream as well as the macroscopic and microscropic alterations common to the blood vessels themselves —arteries and arterioles, veins and venules, as well as the capillaries. In addition to this, because the choroid is the most important nutrient coat of the eye, it is functionally the *sine qua non* of retinal integrity, hence of vision. Diseases which affect it may also involve the retina even to the subsequent destruction of the retina.

The retina, with a second basic blood vessel system, one peculiarly its own, is of neural ectoderm origin and presents not only the changes from blood vessel pathology, as just discussed relative to the choroid, but also those conditions to

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which nerve tissue is heir, nerve tissue cells and fibers, both supportative and conductive—as each is individually involved, regardless of the basic etiology. The large ganglion cell bodies of the retina, the source of the optic nerve fibers to the external geniculate body, will show a selective affinity to various etiological factors quite different from that seen in another portion of the retina itself, as for example the rods and cones, and the contiguous pigmented neuroepithelium. Even the different types of nerve fibers themselves within the eye and in the cerebral pathways, respond differently to infections, to disturbed metabolic processes, and to the degenerations of senescence. The nerve fibers, both somatic and autonomic, for the iris reflex arc, and the pure visual fibers illustrate these diverse responses.

The optic nerve must be considered, ophthalmologically, as a part of the retina, as well as a separate anatomic structure. The common finding is for pathology in one of the two to be accompanied by simultaneous and/or consequent pathology in the other. This is not necessary, however. Either may show pathological changes with the other remaining essentially normal, at least normal from a histological standpoint.

There is still an additional point to be considered, at this time, relevant to this discussion. It implies nothing whatsoever pedantic in nature. The ophthalmologist should differentiate a retinosis from a retinitis, excluding one from the other—ophthalmoscopically as well as etiologically. The various forms of retinopathy could be better discussed, under all possible circumstances, if this was done more meticulously by authors and clinicians. There are so many good reasons in favor of it, and none whatsoever contrariwise.

This paper today has, as the reason for its being, the presentation to you of various diseases of the ocular fundus, the result of inflammatory diseases of the choroid, the retina, and of the optic nerve. The presentation (it is hoped) is not ophthalmic but simply medical and intrinsically narrative.

The number of conditions which could be included is not large, and of these only a rather small number is being included. They cause a retinitis, a choroiditis, or an optic nerve neuritis, or any one of the possible combinations of these three structures.

Tuberculosis and syphilis, the retinal changes from such pyemic conditions as bacterial endocarditis (subacute especially), the fundus findings in septicemia, and the chorioretinitis of such conditions as vaccina and toxoplasmosis are to be discussed. The qualifying term—inflammatory—limits the paper rather sharply, but purposely.

Tuberculosis periphlebitis, tuberculous periarteritis, primary retinal tuberculosis, tuberculous chorioretinitis, the acute and chronic forms of miliary tuberculosis, primary tuberculosis of the optic nerve, massive tuberculoma of the fundus (probably an extensive form of choroidal tuberculosis), and extension of tuberculous pathology from other ocular structures are the usually accepted types of this disease. Retinitis exudative, probably better known as Coats' Disease, has at times been considered a tuberculous inflammatory condition but not so by Coats[2] himself. Leber[18] assumed, according to Elwyn[6] an inflammatory and necrotizing process in the retina to be the cause, but Leber's own microscopic findings eliminated this process as such, and placed it in that class, shown by Elwyn, to be due either to an abnormal constitution of the blood itself, or to a primary change in the blood vessels, especially the smallest of these.

Tuberculous periphlebitis, also known in part as Eales disease,[3] is a disease usually of the late second and third decade of life, characterized by recurrent retinal and vitreous hemorrhages, a marked proliferation of connective tissue about the retinal veins and into the retina, and results not uncommonly in blindness either by retinal separation or because of a secondary glaucoma. The course of the disease may be long in duration, with repeated recurrence and with intervals of quietude.

Schmidt[15] called our attention to the irregular relationship this has to generalized tuberculosis, especially the pulmonary form. In eight cases which he studied and followed, three showed tuberculosis of the lymph nodes, the possible source of the ocular infection; one case had a tuberculous focus in a tonsil, and in four cases the ocular disease preceded manifestations of tuberculous pulmonary disease, in one case by as much as three years. Schultz[16] also was certain that this disease is due to a tuberculous process in the vessel wall and bases his treatment, because of this, upon rest, diet, and tuberculin therapy.

A case of this, unilateral, in a male, studied microscopically, by de Long and the author,[17] showed well the massive perivascular changes

present in the fundus. This patient has had no change in his basic, primary tuberculous condition, which was that of a cervical adenitis, nor has the left eye shown any fresh pathology for over five years. The bacillus tuberculosis has been recovered in several instances, from the retinal phlebitis; this, with the positive skin sensitivity test, plus a significant history, in many cases, seems to confirm the diagnosis and etiology.

Retinal phlebitis, limited wholly to the central retinal vein, has been reported, but it is a very rare condition. Retinal periarteritis has also been found, though perhaps even more rarely. In one case reported by Muncaster and Allen,[11] the retinal vessel pathology seemed to be precipitated by the intradermic use of tuberculin—suggesting an allergy-like etiology for these vascular conditions.

Primary retinal tuberculosis and tuberculoma of the choroid, though separate entities, may be considered together, for our present purpose. These conditions progress to the secondary involvement of other portions of the eye, and usually end in an imperative enucleation because of caseous necrotic degeneration of the eyeball. In three cases seen by the author, two have, over a period of four to six years, shown no other new clinical signs of tuberculosis. The third case progressed to extraocular extensions of the tuberculoma, with severe exophthalmos before death occurred from extensive tuberculous pulmonary pathology.

Tuberculous choroiditis, with its consequent retinal involvement, including chronic miliary tuberculosis, also including that rather interesting form of chorioretinitis with pathologic sectioning of the optic nerve fibers at the optic nerve disc margins, known as chorioretinitis juxtapapillaris, are common diseases of the ocular fundus. No anatomic portion of the fundus is spared, and there is no predilection for the ocular blood vessels. These conditions are chronic, with frequent recurrences, and with the formation of new lesions in fresh portions of the fundus. They are diseases of early adult life, and are apparently a bit more common in females. These conditions have an onset of sharp inflammation, followed by self-limitation of the lesion, by necrosis of the inflammatory area and pigment deposition. A quiescent chorioretinitis remains, showing areas of atrophy of the retina and the choroid (the sclera being bared); these lesions rimmed about with deposits of pigment, and frequently with some residual pathological vascularization. Desseminated chorioretinitis, as outlined above, frequently fails to show other positive clinical signs or symptoms of tuberculosis. The active tuberculin skin sensitivity reactions, even in very small dilutions, and the focal reaction to these seen in the fundus lesions are the indicators to the etiology.

This type of fundus pathology has an unusual relationship to systemic disease. Two characteristics are outstanding. The first is the marked remedial effect which desensitization with tuberculin has upon the course and progress of these conditions—suggesting, in fact almost demanding, some allergy-like relationship between tuberculosis antibodies and the fundus pathology. The second is this: almost twenty years of experience as an associate consulting ophthalmologist, and then later as consulting ophthalmologist to a very active Municipal Tuberculosis Hospital have failed to uncover a single such case. These years instead have shown a number of cases of acute generalized miliary tuberculosis with true miliary tubercules in the fundi. These cases all died, frequently of tuberculous meningitis.

One cannot help but agree that these varied conditions, and not including tuberculous lesions of the iris and the sclera, though all tuberculosis, are each a distinct clinical entity. One acute miliary type is the result of a fatal bacteriemia; the other is an allergy, and reacts as such; one results in classical caseation necrosis; another in the formation of sheets and bands of scar tissue without demonstrable necrosis; one involves only the blood vessels (an artery or the veins); another attacks nonvascular tissues—one the retina, the other the choroid; and each of these has its characteristic appearance, and its individual course. Considering this, there is some reason for the lack of unanimity among ophthalmologists in the treatment of these allied but varied conditions.

Syphilis, like tuberculosis, can involve practically each different anatomical structure of the eyeball in a clear-cut distinct pathological entity. The changes seen in the fundi result from either a congenital or an acquired luetic infection and each is fairly distinctive in character. Syphilitic chorioretinitis may be a manifestation of secondary lues, though it usually is tertiary, and intraocular gummata are still seen occasionally. This type of case, and that seen witth secondary lues, are becoming rather rare—probably because of recent changes in therapy.

Neuritis of the optic nerve may be a primary ocular condition resulting in a postneuritic type of optic nerve atrophy. A descending type of optic atrophy may appear, originating in the syphilitic cerebrospinal pathology of taboparesis.

There has been some controversy as to whether these fundus conditions (excluding primary pathology of the optic nerve) are either choroiditic in character, with secondary retinal involvement, or the reverse. Nettleship[12] believes that both occur at different times. Clinically one can see cases in which the retinal vessels show syphilitic inflammation with the choroid free from pathology. Igersheimer's[6] opinion is that in syphilis the organisms are transmitted by the blood stream and cause the retinal, choroidal, neural, or vessel pathology, and by the direct action of the organisms, or through their toxins start an inflammatory process which extends to contiguous tissues. Extensive, but somewhat distant pathological changes, as in syphilitic pigmentory degeneration, is due probably to the damaged nutrition of the retina and the choroid by primary vessel pathology.

The most common ocular manifestation of congenital lues is not disease of the fundus. Interstitial keratitis is certainly much more frequent. This disease, however, seems to be an allergic manifestation of congenital lues—judging from the vagaries connected with its onset, its course, and the responses this diseased condition shows to various non-specific forms of treatment. A similar group of ocular conditions has been mentioned in regard to tuberculosis. It is perhaps significant to this also that luetic corneal pathology and luetic vessel pathology, both present in the same case simultaneously, are quite uncommon. This should exclude cases of peripheral atrophy of the retina and other changes consequent to the syphilitic iridocyclitis so often an accompaniment of interstitial keratitis.

The so-called salt and pepper fundus, very well named, is perhaps outstanding in the matter of incidence. It is a disease of the pigment epithelium and according to Elwyn is a common accompaniment of interstitial keratitis. Before that confirmation by Elwyn this was suspected by the author upon some clinical experience. The progress of this condition is slow, though its onset is very early in the child's life. Vision is involved, but often only to a rather slight extent. The disease can remain unchanged for many years, and antileutic treatment seems to affect it but very little.

Another form of congenital luetic fundus disease is that of secondary or luetic pigmentary degeneration of the retina. This resembles true retinitis pigmentosa in the visual impairment, to some extent in the visual field changes present, and to a great extent in the anatomic distribution of the pathology. The appearance of the pathology, however, is quite dissimilar and should not confuse the ophthalmologist. The prognosis in this type of disease is absolutely bad. The disease changes are a manifestation of severe chorioretinitis, with involvement of the pigment epithelium, and with an obliterative arteritis of the retinal vessels and a postretinitis atrophy of the optic nerve fibers. Even if the process could be halted, early in its course, established damage would be so extensive to recipient and conductive visual elements that improvement in visual acuity would be impossible.

The rarest form of congenital lues is that of primary luetic retinal vascular disease. This form has some relationship to that type of disease just discussed, except that pigment changes are at a minimum and the obliterative arteritis with consequent postretinitic atrophy is quite marked. In addition to the retinal vascular pathology, these cases are probably more often accompanied by other ocular signs of degeneration due to disturbed nutrition based upon this discriminative type of vessel disease. It is a very fine example of the vascular diseases so characteristic of syphilis. Luetic aortitis, meningovascular lues, this form of vascular pathology, and that about to be described, are all closely related members of the same clan.

Retinal vascular pathology of acquired lues involves both arterioles as well as the venules, perhaps pathology in the arterial system being somewhat more frequent. The condition is an inflammatory form of obliterative arteritis or phlebitis, involving both the intima and the adventitia, with round cell infiltration, destruction of the muscularis coat, and with some to extensive perivasculitis. In a case studied microscopically by Von Hippel[5] the extensive circulation of the choroid remained normal. The postretinitic atrophy which develops in these cases seems to suggest that the disease while vascular is largely retinal in anatomic detail.

Syphilitic retinitis, or chorioretinitis or retinochoroiditis, is a diffuse disease of the fundus, and is characteristically a disease of secondary lues, at least appearing rather soon after the primary in-

fection. Roenne's[13] analysis of fourteen of these cases following Leber's classical recapitulation of our knowledge of this disease remains as our *vade mecum*. The disease, as a recent acute condition, is now relatively uncommon but the later stages of the untreated cases are more frequently seen. The later stages of the condition have an appearance not unlike that described under congenital lues as a secondary pigmentary degeneration. A microscopic study of this disease by Rochon-Duvigneaud has been made and the pathology is largely vascular and retinal.[14] The outstanding characteristics are those subjective signs of visual disturbances classical for an acute chorioretinitis, with the tragic postretinitis optic nerve atrophy which follows an unsuccessfully treated acute condition. These sequelae of the condition if first seen at the primary examination are hopeless for ocular improvement, but should be vigorously treated nevertheless, because clinical experience seems to indicate that these cases later on are potentially neuroluetics, terminating as cases of meningovascular syphilis.

Cases of intraorbital and epibulbar gummata are still not too uncommon. It is interesting, however, and the reason is not clear, but intraocular gummata are now most uncommon. The vital point is this, as every case of unilateral exophthalmos from an intraorbital space-taking lesion must have a Wassermann examination before orbitotomy—so also must every case of intraocular solid retinal detachment have serological studies before disposition is made of that case. A patient with a certain intraorbital gumma will have other general luetic complications, more important to that patient's life than the orbital condition. This is also present in the consideration of a case of intraocular gumma. That, perhaps, is the outstanding factor in these individuals.

Syphilitic optic neuritis, not considering for the moment the primary luetic atrophy of taboparesis, is an acute, intensely severe luetic condition, a manifestation of tertiary syphilis, with a sudden abrupt onset, and rather prone to recurrence when inadequately treated. The condition, when properly treated, has the best prognosis of any of the luetic intraocular conditions, excepting that of gumma.

Primary luetic optic nerve atrophy is a sign of cerebrospinal lues, in fact is diagnostic of that condition, and if untreated or treated unsuccessfully has a tragic termination in visual impairment. There is no other luetic condition in which the demands for treatment are greater. Vigorous, intensive treatment, based upon proven and accepted physiopathological principles is absolutely necessary. Tryparsamide, however, cannot be used in any ocular condition in which optic nerve fiber damage is present at the time the antiluetic treatment is started. A sharp increase in the nerve damage, with inexorable progress in this, will almost certainly result.

The inflammatory conditions connected with a septicemia also develop because of the direct effect of organisms transmitted to the retina or the choroid by the blood stream. The ophthalmitis of infancy and early childhood, commonly known as pseudoglioma, is not rare. It results in a complete destruction of the retina and the choroid, developing into a subretinal granulomatous-like mass of cell debris which must be differentiated from a true retinoblastoma. This is not always a simple thing to do. Fortunately, an enucleation, if done for a mistaken diagnosis of true glioma, is not an unwise surgical procedure. Of outstanding importance therefore, in this condition, is that it be not mistaken for true glioma. The reason for the limitation of this disease to childhood has never been well answered. The prognosis is hopeless.

Another fundus condition, although indirectly caused, is sufficiently relevant to be included herein. This is the fundus picture of thrombosis of the cavernous sinus, a not unimportant part of a cavernous sinus symptom complex. In these days of chemotherapy the prognosis of this condition has become much more favorable. It formerly was almost certainly fatal. The fundus changes of this are the result of the peripheralward extension of the septic, inflammatory thrombotic process in the cranial vascular sinuses.

The fundus changes seen with subacute bacterial endocarditis could be due in part to some allergic-like phenomenon, the result of dead organisms in the lumen of the vessels, for frequently the retinal petechial hemorrhages seen are similar to and accompanied by a superficial skin and mucous membrane purpura. More important are those fundus changes, the result of septic emboli which have broken free from the cardiac valve vegetations. These result in foci of necrosis with not infrequently extensive inflammatory changes

in the retina, the choroid, and the optic nerve. These foci, early in their appearance, show a rather characteristic ophthalmoscopic picture. One must not forget that when these appear in the ocular fundi, then also are such septic foci present in the kidney, the spleen, and the brain. They appear late in the course of the disease, and naturally are of grave prognostic import.

Other similar changes of septicemia may appear, excluding those of bacterial endocarditis, and the pseudoglioma (a type of endophthalmitis) of infancy and childhood. These include panophthalmitis, endophthalmitis, and metastatic chorioretinitis.

Panophthalmitis is relatively rare except for those cases with initial corneal infection and a subsequent iridocyclitis, and the post-traumatic and postoperative infections with either an external route infection implantation or by a systemic infection of an operated or otherwise traumatized eye. These cases are ophthalmological problems, however, and not quite relevant to the scope of this paper. Sufficient to say, with Elwyn, "When the patient does not succumb to the septicemia, the globe gradually becomes disorganized and remains as a shrunken blind eye."

Endophthalmitis can be considered a metastatic ophthalmitis of a lesser acute severity than that of panophthalmitis. Also, it has a slightly more favorable prognosis, as well as a less severe subjective group of symptoms. This especially is true since the use of intraocular and subconjunctival injections of penicillin. Relevant here is the clinical experience which indicates a greater benefit from this local application of penicillin rather than from other more distant injections for general absorption. Another clinical point of interest in these cases is the ability to determine the source from whence the infection spread in a small number of instances. These are the cases which seem to originate in such loci as—infected external hemorrhoids, following a carbuncle high in the cervical region, and after the removal of a severely infected tooth. (The instances quoted were actual cases—one eye only saved in the three mentioned.)

Clinically and ophthalmoscopically, (excluding local subjective symptoms), the outstanding point in the diagnosis of these two conditions is the great rapidity with which the fundi become obscured by precipitates on the cornea and the lens, and the exudates in the pupillary aperture and in the vitreous chamber. The normal red reflex from the ocular fundus will disappear, in some cases, within 48 hours. Some cases of metastatic chorioretinitis may remain limited to localized retinal abscesses in a certain sector of the fundus, but this is a rather rare situation. One such case was seen by the author in consultation, in which the first impression was that of a possible intraocular neoplasm. The marked inflammatory reaction present, and the rapidity with which this advanced were most important in arriving at the correct diagnosis.

The last of the inflammatory conditions to be mentioned in this presentation are those connected with two forms of encephalitis. The first is that of toxoplasmosis and it is not a pure infancy condition. According to Koch[7] and his co-workers and to Lucic,[10] the essential pathology is that of inflammatory necrotizing lesions in the eye, as in the brain, with subsequent extensive retinal and choroidal degeneration and with a large amount of pigment deposition. Other ocular malformations are not uncommon. As is well known, human toxoplasmosis can result in an extensive diffuse disseminated encephalomyelitis in infants, in older children as a milder infection and in adults with pulmonary complications. As Lucic said, "The large reservoir of spontaneous toxoplasmic infection in rodents and birds is the likely source of the human infection." We do not know the pathway of this infection to humans but the infantile infection is through the placenta.

The second of this last group of cases is the manifestation of the encephalitis which, fortunately, only rarely complicates vaccination. The ocular pathology is inflammatory and granulomatous in character, focal in nature, and according to Braun[1] affects the nerve fiber and ganglion cell layers of the retina. Braun assumed this to be an endogenous intraocular infection, perhaps precipitated by injury, and the complication of a mild vaccinial encephalitis.

While the etiology of sympathetic ophthalmia is still unknown, this also is an inflammatory granulomatous condition of the intraocular structures and for record alone must be included herein. The condition does not need a perforating lesion of the eyeball for its development, though that is the most common precipitating cause. Prevention of the disease is its best treatment for once it be-

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Missed Meckel's Diverticula

Presentation of Nine Cases

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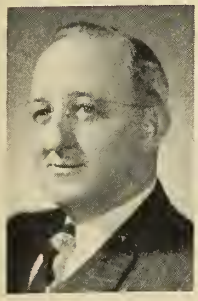

We must become Meckel's diverticulum-minded. It should be carefully sought for each time the abdomen is opened. Many times it is found at the second or third operation. Recovery following its removal, even when the diverticulum appeared innocent of acute pathologic changes, raises the question of the necessity of the last two operations. Errors of this kind, then, can be eliminated by thoroughly examining each abdomen that is opened, not by vision alone, but also by palpation. The small intussuscepting diverticulum causing partial obstruction cannot be seen.

This anomaly was described by Lavater in 1671, Ruysch in 1707, Morgagni in 1769 and, finally and most completely, by Meckel in 1809. The communication between the embryo and the yolk sac is wide at first, but by the sixth or seventh week, it has narrowed down to a fine fibrous band which finally parts and disappears. If the vitelline or omphalomesenteric duct persists, one can expect a wide variety of malformations, varying from a small dilatation in the intestinal wall to a large sac-like formation causing intestinal obstruction without adhesions, as reported by Cabot in 1940.

Histologically, the structure is usually that of the ileum. It has the same number of muscular layers and the mucosa pattern is usually similar. Epithelial heterotopia may resemble gastric, pancreatic, duodenal or colonic mucosa. This, then, would give a structural basis for the wide variety of symptoms. The tip of the diverticulum may lie free or be attached to the umbilicus, mesentery or any portion of the gut, thus introducing such conditions as intussusception, volvulus, kinking, twisting and complete intestinal obstruction, with its concomitant symptomology.

This is aptly demonstrated by perusal of the literature since 1940. One encounters intriguing reports, such as "Invagination of a Meckel's Diverticulum," by Hanelin;[7] "Significance of Meckel's Diverticulum," by Stewart;[15] "Surgical Emergencies During Childhood Caused by Meckel's Diverticula," by Chaffin;[2] "Hemorrhage from Meckel's Diverticulum," by Shapiro;[14] "Meckel's Diverticulum Causing Obstruction by Tying Knot Around Adjacent Ileum," by Darling;[5] and "Massive Hemorrhage from Meckel's Diverticulum," by Sacks.[13] Other reports cover volvulus, foreign bodies including calculi and one diverticulum even contained a miniature stomach.

It readily becomes apparent from the above why one cannot produce a classification of symptoms that will cover all the wide variations. There are a few findings which seem to be fairly consistent. The patient usually complains of an intermittent recurrent type of colicky pain, which tends to localize under the midportion of the right rectus and about 1 cm. above the umbilicus. There is frequently bright red or tarry stools accompanied by a secondary anemia, with an upper gastrointestinal tract that is roentgenologically negative. MacCarty,[6] Rousseau and Martin,[11] and Poppel[10] have written articles on the value of x-ray as an aid in diagnosis. It would appear that the lateral and oblique views are of value in a small percentage of cases.

The problem, then, as we see it, resolves itself into a consideration of two types of cases. Those showing severe acute symptoms as in hemorrhage, volvulus, intussusception, gangrene, and intestinal obstruction are readily recognized as acute abdomens and, in the vast majority of cases, are well treated. The second classification demonstrating chronic, intermittent, recurrent, symptomology are, we believe, often poorly treated, and even missed while performing intra-abdominal operations.

With this thought in mind, 3,460 intra-abdominal operations performed in the Florence Crittenton Hospital in the past five years were reviewed, with Meckel's diverticulum occurring nine times. According to a large series of consecutive autopsy reports, Meckel's diverticulum occurred in 2 per cent. This, then, would indicate that out of an estimated sixty-nine diverticula, only nine were discovered. From a review of the literature, we believe this is quite the usual average. A summary of these cases follows. (See table.)

SUMMARY OF CASES

Case No.	Age	Color	Sex	Diagnosis		Operation	Laboratory Reports	Tissue Diagnosis
				Preoperative	Postoperative			
3076	38	W	F	Chronic appendicitis	Chronic appendicitis Meckel's diverticulectomy	Appendectomy Diverticulectomy	2 Blood counts 2 Urinalysis 1 Serology-neg.	Inactive appendix Meckel's diverticulum
4820 B	34	W	F	Retroversion of uterus	Retroversion of uterus Meckel's Diverticulum	Baldy-Webster suspension Diverticulectomy	1 Blood count shows secondary anemia 3 Urinalysis 1 Serology-neg.	Meckel's diverticulum
2932 B	16	W	F	Recurrent appendicitis	Recurrent appendectomy Meckel's diverticulum	Appendectomy Diverticulectomy	1 Blood count 1 Urinalysis 1 Serology-neg.	Mild catarrhal appendix Meckel's Diverticulum
84799	29	W	M	Postoperative adhesions	Postoperative adhesions Meckel's diverticulum	Lysis of adhesions Diverticulectomy	1 Blood count 2 Urinalyses 1 Serology-neg.	Meckel's diverticulum
73477	23	W	F	Menorrhagia Retroversion Incomplete abortion	Menorrhagia Retroversion Meckel's diverticulum	D & C Uterine suspension Diverticulectomy	1 Blood count 2 Urinalyses 1 Serology-neg.	Degenerating decidua and placenta Meckel's diverticulum heterotopic gastric mucosa
67429	33	W	F	Acute appendicitis Acute Meckel's diverticulitis	Chronic appendicitis Acute Meckel's diverticulitis	Appendectomy Diverticulectomy	WBC 17, 850 Poly .93 NF23 10 RBC 20 WBC Epith. cells mucous in urine not catheterized	Chronic appendicitis Acute Meckel's diverticulitis
1303	23	W	M	Subacute appendicitis	Chronic appendicitis Chronic Meckel's diverticulitis	Appendectomy Diverticulectomy	WBC 10,900 2 Urines 1 Serology-neg.	Mild obstructive appendicitis Meckel's diverticulum
3377	23	W	F	Recurrent appendicitis Cervical laceration	Chronic appendicitis Meckel's diverticulum Cystic right ovary	Appendectomy Diverticuoophorectomy Right, partial	1 Blood count 2 Urinalyses 1 Serology	Inactive appendix Meckel's diverticulum Hemorrhagic luteal cyst
3114	27	W	F	Recurrent appendicitis	Chronic appendicitis Intussusception of Meckel's diverticulum	Appendectomy Diverticulectomy	1 Blood count WBC 10,000 2 Urinalyses 1 Serology-neg.	Pressure changes in appendix Acute Meckel's diverticulitis

* I wish to express my appreciation to the surgical staff of the Florence Crittenton Hospital for permission to review those cases not my own.

From the summary it is noted that:

1. Only two males are listed. This is undoubtedly due to the fact that a large majority of the abdominal surgery performed is gynecology.

2. In only one case was a preoperative diagnosis made of "Acute Meckel's Diverticulitis," which is in keeping with other reports.

3. The most frequent preoperative diagnosis was "appendicitis."

4. The only case examined by x-ray was reported as having pericecal tenderness. At operation, it proved to be an intussusception of a Meckel's diverticulum.

5. The only positive laboratory findings were in the two cases of "Acute Diverticulitis," where the white blood count was 17,850 and 10,000, respectively.

6. Three cases had had previous abdominal operations and the diverticulum had been missed.

7. Whether acute or inactive, all cases have been benefited by the surgery performed, and we feel the diverticulectomy mainly responsible.

Conclusions

1. Only 17 per cent of existing Meckel's diverticula are discovered during intra-abdominal operations.

2. Recovery occurs frequently enough following diverticulectomy, even if not acutely inflamed, to warrant its removal with very few exceptions.

3. Only ten per cent of those removed are diagnosed preoperatively.

4. The small intussusceptions cannot be seen but are readily found by passing the gut through the fingers.

5. The laboratory and x-ray offer little aid in the diagnosis.

6. In this series, 33⅓ per cent had had previous intra-abdominal operations and the Meckel's diverticula were missed. In all three, the abdominal symptoms disappeared following diverticulectomy.

7. Diverticulum should be suspected if there is tarry or bright red bleeding per rectum and when the upper gastrointestinal tract is roentgenologically negative.

8. Intermittent colicky pain localized just above and to the right of the umbilicus is a frequent symptom.

9. Simple resection, with the clamps parallel to the long axis of the bowel and inversion of the base transversely, is the usual procedure. Occasionally, a resection of the involved ileum is necessary with closure of the ends and side-to-side anastomosis.

References

1. Cabot, Hugh: Meckel's diverticulum with intestinal obstruction. Case report, New England J. Med., 222:195-197, 1940.
2. Chaffin, L.: Surgical emergencies during childhood caused by Meckel's diverticulum. Am. J. Surg., 113:45-56, 1941.
3. Clark, C. W.: Irreducible double intussusception due to Meckel's diverticulum, complicated by volvulus. Brit. J. Surg., 31: 301-303, 1944.
4. Conrad, H. A.: Meckel's diverticulum. Two cases. Am. J. Surg., 52:267-274, 1941.
5. Darling, G. C.: Meckel's diverticulum causing obstruction by tying knot around adjacent ileum in man, seventy-four years. Brit. J. Surg., 29:277, 1941.
6. Gile, J. F. and MacCarty, W. C., Jr.: Calcified concretions within Meckel's diverticulum (with fistulous connection with appendix). Radiology, 41:491-494, 1943.
7. Hanelin, H. A.: Meckel's diverticulum with invagination. J. Michigan M. S., 39:786, 1940.
8. Mulsow, F. W.: Meckel's diverticulum containing calculi. Case. Am. J. Digest. Dis., 10:188-189, 1943.
9. Noel, W. W.: Meckel's diverticulum. Am. J. Surg., 49:454-463, 1940.
10. Poppel, M. H.: Meckel's diverticulum, roentgen demonstration. Am. J. Roentgenol., 51:205, 206, 1944.
11. Rosseau, J. P. and Martin, A. G. M.: Meckel's diverticulum, preoperative roentgen diagnosis. Radiology, 40:605-607, 1943.
12. Rottiman, M. and Zetena, D. F.: Meckel's diverticulum as cause of intestinal obstruction; case of volvulus. Am. J. Surg., 60:443-446, 1943.
13. Sacks, M. S.: Massive hemorrhage from Meckel's diverticulum. Two cases. Bull. Sch. Med. Univ. Maryland, 27:197-203, 1943.
14. Shapiro, B. and Tosti, O. G.: Hemorrhage from Meckel's diverticulum. Four cases. Arch. Pediat., 59:295-302, 1942.
15. Stewart, G. A.: Significance of Meckel's diverticulum in surgical abdomen. Rev. Gastroenterol., 7:310-312, 1940.
16. Waugh, T. R.: Miniature stomach in Meckel's diverticulum. J. Tech. Methods, 24:55-60, 1944.
17. Wilson, H.: Meckel's diverticulum, with report of twelve cases. Am. J. Surg., 56:614-618, 1942.

MSMS

NEW CRIPPLED CHILDREN RATES

The Legislature in 1947 amended the Crippled Children and Afflicted Adult laws giving increases in medical and hospital fees. The top limit on medical fees is raised from $75 to $90, a 20 per cent increase. This is still not adequate but is an improvement.

Other changes were made. Hereafter, the doctor must render his bill on forms obtainable at the hospital. These must go to the State office in Lansing and be sufficiently descriptive of the services rendered to allow the paying officers to check the amount due. Code numbers are now supplied but there is danger of mistake, so billing by name and description of service is preferred.

By law, bills rendered over sixty days after the service is concluded are void. It pays to bill every thirty days and take no chances. This is good policy in all types of practice.

MEDICAL BROADCASTS

In 1947—the centennial year of the American Medical Association—the Bureau of Health Education is adding to its electrical transcriptions for use by local radio stations a series on surgery, foods and physical medicine. Nearly 5,000 local broadcasts will be made from these transcriptions in the course of a year.

Approximately 120 radio stations of the Mutual Broadcasting System have carried the program entitled "Stephen Graham, Family Doctor," which has been produced under the supervision of the Bureau.

Michigan Postgraduate Clinical Institute

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Parenteral Fluid Therapy

Paul V. Woolley, M.D., Detroit, Michigan

Parenteral fluid therapy serves four elementary purposes in modern pediatrics: (1) it provides water when adequate amounts cannot be taken by mouth, (2) it adjusts and maintains electrolyte patterns disturbed during disease, (3) it allows replacement or augmentation of blood proteins and formed elements, (4) it maintains and enhances nutrition when oral feedings are not satisfactory.

Despite efforts to develop new methods for parenteral therapy, the intravenous and subcutaneous routes remain most valuable. Water is rarely considered apart from electrolytes since it parallels these so closely in all metabolic processes. The fluid or water requirements at various ages were discussed and the safe therapeutic ranges outlined.

While sodium and chloride are the most important electrolytes, the use of unbalanced solutions such as sodium bicarbonate and sodium lactate is often advisable. The intelligent use of parenteral electrolytes depends upon a thorough understanding of normal electrolyte physiology, and the brief principles underlying this are discussed.

Augmentation of blood proteins and foreign elements is obtained by the use of whole blood plasma, plasma fractions, and packed red cells. The ability to supply nutrition over extended periods of time is one of the real developments of the past two years. Proteins, carbohydrates and accessory substances are all available in forms satisfactory for parenteral administration and the use of these is discussed.

Many children are living today, who, under the conditions existing twenty years ago, would have had a hopeless outlook. This is due largely to the pediatrician's ability to provide them with plenty of water, vitamins, food, and blood by way of their skin and veins. Even a very sick baby with severe diarrhea can be handled in this manner. The surgeon is able to perform operations previously impossible, since his small patient can be carried through the time when he is unable to eat entirely by intravenous feedings. The small child who has been burned often must be provided blood serum for weeks following his accident and now has a chance for recovery never before available. Certain infants have been fed and their weight maintained for weeks through the use of intravenous feedings and have gone on to develop into normal babies. The types of food to be used for each condition were discussed as well as the methods for providing these fluids.

The Significance of the Lowered Basal Metabolic Rate

R. M. McKean, M.D., Detroit, Michigan

With the several offerings of Fagge, Gull, Ord and Kocher in the 1870's and 1880's, the relationship between thyroid deficiency and myxedema and cretinism was established on a firm basis. Bauman, Kendall and Harington, respectivelly, between 1895 and 1927 noted the predominant presence of iodine in thyroid gland material, isolated the active principle—which was termed "thyroxin"—and identified this principle as an iodo protein, tetraiodotyrosine. Widespread investigations since that time have suggested a number of potential causes for a deficiency in effective thyroxin, notably (1) the lack of necessary building stones, particularly iodine and l-tyrosine; (2) the inability to synthesize properly the prod-

NOTE: Other papers presented at the Institute were published in the May and June, 1947 issues.

uct in the gland; (3) an inhibition of the mature secretion peripherally (perhaps due to an antihormone); and (4) the lack of a normal stimulus, notably the thyrotropic hormone of the anterior pituitary gland. These factors were given detailed discussion.

In the past quarter century, the intimate relationship of the thyroid gland to the maintenance of normal heat production has been recognized, and an increasing attention has been devoted to this point in clinical medicine. An appreciation of the importance of oxygen utilization and carbon dioxide excretion as a satisfactory means of measuring heat production in the living organism, has led to its application in the development of methods for the study of human basal metabolism in health and in various disease states.

In this discussion, we were concerned with those readings consistently on the low side of the accepted norm. These we termed the "hypometabolic states," and a classification was offered covering this group from clear-cut myxedema and cretinism at one end of the clinical spectrum, through varying degrees of nonmyxedamatous hypothyroxinism, down to that nebulous group whose only positive finding is a persisentenly lowered metabolic rate. Therapeutic implications of the various members of the "family" were noted.

Treatment of Common Fractures

Homer Stryker, M.D., F.A.C.S., Kalamazoo, Michigan

In fracture work the good result is soon forgotten by the patient and his friends; the poor result is a walking advertisement, an ever-present reminder of your handiwork, which puts you permanently on the "who done it" list of all the patient's friends.

A good result in many fractures is impossible regardless of the skill of management; but by carefully following the fundamental principles of fracture treatment, by mastering the technique of several methods of reduction, by proper selection of the method after a careful analysis of the patient and his injury, and by eternal and constant vigilance, the poor results can be held to a minimum.

The fundamental principles of fracture treatment are:

1. Reduce the fracture as nearly anatomically as is possible without violence.
2. Hold the fragments continuously reduced without a moment's interruption until healed.
3. Mobilize and exercise all joints not requiring immobilization for the maintenance of the reduction.
4. Continue your counsel and treatment until the patient is physically, mentally, and psychologically completely rehabilitated.

What should be the standard of reduction?

1. Perfect alignment with no angulation.
2. Minimum of rotation.
3. Maintain length to within one-half inch if the fracture is in a lower extremity.
4. No distraction.

What are the methods of reduction?

1. Manipulation and plaster fixation.
2. Traction and countertraction.
3. Open reduction, with or without internal fixation.

Slides of patients were shown to emphasize the value of adhering to these principles, to point out some of the more common violations and their dangers, and to suggest some points which may help solve some of the problems in the treatment of these fractures. Cases illustrated were fractures of the wrist, forearm, elbow, ankle, knee, and hip.

Antihistamine Substances

Stanley W. Insley, M.D., Detroit, Michigan

The use of antihistaminic substances in the treatment of various allergic conditions is predicated on the theory that a release of free histamine, during an allergic contact, has a role in the production of many of the allergic symptoms.

This concept of histamine release during an allergic or anaphylactic syndrome was first brought out as far back as 1911 by Dale and Laidlow. A number of investigators, chiefly Lewis, have since confirmed and enlarged upon this idea, and the way was thus paved to a search for new drugs and chemicals which might safely neutralize the excess histamine-like substances noted during allergic reactions, and bring at least some of the distressing symptoms under control.

The antihistamine substances of which we shall speak, do *not* apparently have any effect on the specific protein-antibody reaction. These substances also do *not* neutralize some of the other by-products of an allergic reaction, such as hepa-

rin. The antihistaminics really belong to the category of alleviating drugs and do not obviate the need for complete studies and adequate management of the allergically sick individual.

The two most widely used American drugs of this antihistaminic type are benadryl and pyribenzamine. There are clinical studies also being made in this country on two new French drugs of this type, namely, antergan and neo-antergan.

The range in dosage of the above drugs for various allergic manifestations and age groups was discussed. The efficacy in various disorders and possible side effects were also pointed out.

The Newer Methods in the Treatment of Anemias

Cyrus C. Sturgis, M.D., Ann Arbor, Michigan

Anemia is a commonly encountered condition in the United States as indicated by its presence in 12.5 per cent of all patients admitted to the University Hospital in Ann Arbor. Fortunately a great many types of anemia are amenable to treatment with iron, liver, folic acid and other antianemia substances. A patient who suspects the presence of anemia should first, by all means, have a thorough examination by a physician in order to determine its type and the best method of treatment. Self-medication is improper because patients often take expensive antianemia substances when they do not have an anemia or they may take the wrong type of medication and fail to take the kind that acts specifically. Folic acid is the most recently introduced drug in the treatment of anemia and is one of great promise. It is helpful in only certain types of anemia, such as pernicious anemia, and careful observations over a long period of time are necessary before the actual efficacy of the preparation can be definitely established.

Atypical Pneumonia

Bert M. Bullington, M.D., Saginaw, Michigan

The disease syndrome of atypical pneumonia has occurred so frequently in the past several years that the clinical manifestations have become known and usually recognized. The etiology has not been established, but there is increasing evidence that a substantial proportion of the cases are caused by a specific virus or viruses.

The illness is characterized by an insidious onset, malaise, headache, chest pains, fever and a paroxysmal harassing cough that is either nonproductive or productive of only small amounts of sputum. The sputum, when present, is usually mucoid and contains only insignificant numbers of bacteria. The white blood count is not characteristic. X-ray findings are out of proportion to the severity of the illness and the physical findings. The x-ray appearance varies, and it is doubtful if the diagnosis can be made by x-ray alone.

Cold agglutination of erythrocytes by the patient's serum develops in the majority of patients. Although this test is neither entirely specific nor absolutely diagnostic, it is a valuable test.

The pathological findings consist of an inflammation along the entire respiratory tract with congestion and infiltration of the alveolar walls with monocytes, lymphocytes and occasional neutrophiles; a similar reaction is present in the peribronchial and perivascular tissues. Small areas of atelectasis are seen. Similar lesions are seen in other interstitial pneumonias of known etiology.

Complications, although infrequent, do occur and consist of recurrences, pseudobronchiectasis, bronchiectasis, and rarely ulceration of the tracheobronchial tree, pleural effusion, and others.

Treatment is symptomatic, with specific therapy being used for the complications.

"Strep" Throat

O. B. McGillicuddy, M.D., Lansing, Michigan

An epidemic of severe streptococcus throat infections on an army air field in 1945 was studied in the Ear, Nose and Throat Department. The infection was not influenced by sulfa compounds but was readily cured by penicillin.

There were hundreds of soldiers who, although they were not ill, had throat cultures positive for streptococcus. These men were examined with mirror and nasopharyngoscope. The latter is a slender tube with a small light at the tip which enables the examiner to see the nasopharynx, that part of the throat located back of the nose and above the palate.

Seventy-eight per cent of these men with positive throat cultures had a large inflamed adenoid mass, while the lower part of the throat showed no inflammation. When the throat cultures be-

came negative, the swelling and redness of the adenoid mass usually subsided.

Controls were examined, men with negative cultures, and in one group exposed to the epidemic only 44 per cent showed a large amount of adenoid tissue. In another group not so exposed the percentage was only 32.

The study seemed to point to the adenoid tissue as an important source and reservoir of infection in this epidemic and probably in all "strep" throats. The amount of adenoid tissue should be determined in all patients, child and adult, who are having recurrent sore throats or obstruction of the tubes leading from throat to ears. If the adenoid tissue is extensive it should be removed or treated by x-ray or radium.

Evaluation of the Serological Test for Syphilis

Arthur C. Curtis, B.S., M.D., Ann Arbor, Michigan

The diagnosis of asymptomatic or latent syphilis is at times most difficult because the only positive factor in the whole realm of laboratory aids is a blood test which in itself is not specific.

The realization that other diseases may produce positive blood tests may prevent one from making a hasty and inaccurate diagnosis of syphilis in one who has a positive test from some other disease.

The introduction of quantitative serological tests have been of great help in evaluating some of these problems. In many false positive blood tests the titre is low and may be evanescent, or changes in its titre may be rapid. In syphilis the titre has a tendency to be higher and more constant when followed for several weeks or months.

The use of both a complement fixation, and a precipitation test in such patients, as well as a detailed history, complete physical examination and a lumbar puncture are necessary in most cases to be sure of the diagnosis. Even after all these studies have been made, the problem cannot be answered, and sometimes one must observe the patient for several weeks or months before a final opinion can be substantiated.

The Treatment of Burns

C. N. Weller, M.D., Detroit, Michigan

Burn therapy may be discussed under the following main headings: treatment of shock; local therapy; management of metabolic and nutritional problems; late care.

The first objective in the therapy of burn shock is the relief of pain, best accomplished by the administration of morphine to the adult and codeine to the child. The intravenous administration of plasma, electrolyte solutions and whole blood transfusions provide the basis for re-establishing fluid balance, and act as replacement agents for the serum exuded from the burned areas. When tolerated by the patient, a mixture of sodium chloride and sodium bicarbonate solutions given orally has proved of value in restoring electrolytic balance. Early anemia is combated by giving transfusions of whole blood. Adequate fluid intake and excretion (as urine) must be maintained. Oxygen is administered if anoxemia is present. The sulphonamide drugs and penicillin have proved of value in combating the infection accompanying deep second and third degree burns.

The pressure dressing applied over vaseline or carbowax is at present a standard method of local therapy and widely used. A protein eschar technique, which is simple in application and nontoxic, has been used with good results by the writer. With this method, second degree burns heal rapidly with minimal infection, while third degree burns are prepared for grafting in a relatively short time.

Throughout the entire course of treatment, careful consideration must be given to the metabolic and nutritional problems accompanying severe burns. The patient's caloric, protein, and vitamin requirements must be supplied. It is desirable that a diet containing 20 per cent of protein, and constituting 1.5 times the basal requirements, be given. If this is tolerated, the adult patient's daily diet is increased in a few days to 3,000 to 4,000 calories. These measures aid in the prevention of a severe hypoproteinemia and a serious nitrogen deficit. Adequate amounts of vitamins A, C, D, and B Complex are routinely given.

The late care of the severely burned patient involves a continuation of the general measures aimed to prevent serious complications. Whole blood transfusions may be necessary to combat secondary anemia. The intravenous administration of blood plasma, albumin, and amino acid preparations may be required to combat hypoproteinemia. Early skin grafting of extensive areas of third degree involvement prevents further loss of fluid, and minimizes the development of scar-

ring. The burned surfaces may be prepared for grafting by the surgical excision of sloughing tissue when adherent, and by wet compresses of saline or Dakin's solutions. Split thickness grafts give, as a rule, the most satisfactory results. In case of burns about joints, the optimum functional position must be maintained during the healing period to aid in preventing deforming contractures. Physiotherapy and plastic surgery may be necessary later if deformities or disfigurement develops.

Sterility in the Female

Norman F. Miller, M.D., Ann Arbor, Michigan

Sterility is an important problem and requires a comprehensive and methodical study. The husband may be responsible for a nonfertile union but as a rule it is not difficult to evaluate the part he may play in this respect. Uncovering the cause of infertility in the woman may be a difficult matter and for this reason it is well to approach the problem in a logical way, so that step by step, the various things which might contribute are thoroughly checked and eliminated.

The simpler studies are carried out first except in those patients where there is abundant reason to believe that nonpatency of the tubes is the primary cause for the patient's failure to conceive.

The customary procedures carried out at the University of Michigan Hospital for patients presenting this problem were covered in this presentation.

Intestinal Obstruction

Charles G. Johnston, M.D., Wayne University College of Medicine and the Detroit Receiving Hospital, Detroit, Michigan

The over-all mortality has been reduced in the past fifteen years. The causes of the reduction in mortality are (1) a better understanding of the control of dehydration and mineral loss, (2) the recognition of distention as the initiating factor for lethal sequellae, and (3) to a lesser extent, the use of antibiotic agents.

Obstruction is frequently only a serious complication of other conditions. It is usally so typical in its symptomatology that regardless of etiology the diagnosis is not difficult. Successful therapy must consider not only restoration of marked physiological relationships, but likewise the correction of the etiological factors.

Early diagnosis is important as it permits therapy before the harmful sequellae of distention are present, as well as early correction of the etiological agent.

The Clinical Diagnosis of the Cardiac Arrhythmias

Carl B. Beeman, M.D., Grand Rapids, Michigan

When a doctor first sees a patient with a cardiac arrhythmia, which means a condition in which the heart is beating too fast or too slowly or irregularly, he may often make a diagnosis at once without the aid of special equipment. By questioning the patient carefully, and by careful observation of the pulse, heart beat, and certain other factors, he may reach a reasonably accurate diagnosis, and hence be able to initiate any necessary treatment promptly. When they develop suddenly, these conditions may alarm both patient and doctor. They constitute some of the more dramatic acute medical emergencies. The chief characteristics of the common arrhythmias, which may be found by relatively simple bedside examinations, were reviewed.

Pain of Spinal Origin

Carl E. Badgley, M.D., Ann Arbor, Michigan

Pain of spinal origin may present a characteristic pattern and pathway of radiation which may frequently be utilized as a localizing sign to determine the site and nature of the underlying pathologic condition. It must be recalled, however, that pain is a cerebral perception and may be produced by an irritative phenomenon occurring anywhere in the central nervous system, even to the terminal sensory fibers, peripheral to the cerebral cortex without cerebral consciousness of the site of the pathologic condition, but with only a sense of localization of the pain pattern.

Pain in the arm, of a definite pattern, so-called brachialgia, may be produced not only by direct nerve root irritation of spinal origin, but by many varied types of lesions located sometimes even quite remote primarily from the central nervous system, but capable of producing a similar pattern of pain.

As much diagnostic acumen is required for

the differential diagnosis of the cause of pain in an extremity, as is necessary to differentiate accurately the cause of abdominal pain.

Various etiological factors found responsible for brachialgia were presented in this paper in clinical case review to demonstrate the variety of lesions which can produce this syndrome. Similarly, low back pain with radiation into the leg may be produced by a variety of lesions.

The author attempted to show that by a return to the teachings of Sherrington for the explanation of pain radiation, with the added clinical research evidence of pain perception throughout the involved nerve root field produced by peripheral tissue stimulation, one can understand that the pain pattern is not diagnostic but may be produced by a variety of lesions in or outside of the central nervous system, therefore, any localized pain requires diagnostic ability to determine its cause, for the source may be in any other part of the body and may be transmitted to the brain.

Respiratory Infections in Infants

Moses Cooperstock, M.D., Marquette, Michigan

A major share of illness in infants is made up of respiratory infections which tend to assume distinctive clinical patterns not observed in older age periods. The common cold, peculiarly absent during the first several months of life, is thereafter prominent in infancy, and its importance is derived from its frequent role as a precursor of more serious complicating infections due to invading pathogenic organisms, chiefly hemolytic streptococci, pneumococci and H. influenzae bacilli. During this period one is likely to observe frequently obstructive inflammatory infections of the respiratory tract, of which acute laryngotracheobronchitis and bronchiolitis are outstanding examples.

Pneumonia, both of the disseminated and lobar varieties, occur with great frequency. While pneumococci are common causative agents, other organisms, particularly hemolytic streptococci, staphylococci and H. influenzae type B, may play dominant roles and with greater frequency than at other age levels. Primary, atypical pneumonia likewise occurs commonly although in less clear-cut fashion than in older children.

Pulmonary infections seen characteristically during the early years are those that follow accidental aspiration of foreign agents of metallic, vegetal and chemical character. Limited to this period are various forms of pulmonary infection which comprise an important feature in the recently recognized clinical entity, fibrocystic disease of the pancreas.

The introduction of sulfonamides and penicillin in the treatment of the variety of infections of the respiratory tract in infants has served to reduce mortality to a great extent and also is responsible for the considerable reduction in the complications of these infections. The ideal and intelligent employment of these agents depends in a great measure on good bacteriologic control.

Abdominal Surgery in Infancy and Childhood

Clifford D. Benson, M.D., Detroit, Michigan

During the past decade, notable advances have been made in the management of surgical lesions of the abdomen in infants and children. Congenital anomalies or conditions of the abdomen making their presence known soon after birth were formerly considered to be almost hopeless because the surgical procedures involved were so formidable that very few infants could survive. The best example of this is pyloric stenosis or an obstruction of the outlet of the stomach which usually makes its presence known by the fact that these infants at the age of two or three weeks begin to vomit their feeding in spite of the fact that the formula is changed to a thicker feeding. The vomiting many times becomes projectile with rapid loss of weight over a short period of time. Since 1912, when a less formidable surgical procedure was devised, the operative mortality associated with this lesion has been reduced from well over 50 per cent to between 1 and 2 per cent. At the present time, the benefits derived from this surgical procedure are associated with permanent cure of the lesion. Obstruction of the small and large bowel in young infants, is also now amenable to surgical correction with a lower mortality rate where formerly they were almost hopeless.

The older child with such conditions as appendictitis, various types of peritonitis, conditions of the bowel requiring removal of a segment of diseased bowel, various diseases of the liver and bile ducts, and the correction of various types of hernia (or rupture) can now be cared for surgi-

cally with a minimum surgical mortality and morbidity rate. This has been possible because of outstanding advances in our knowledge of chemistry, improved surgical techniques, better diagnostic facilities and the application of the well-known drugs such as the sulfa group and penicillin. When these drugs are used in conjunction with the application of sound surgical principles, the mortality of many serious conditions in the abdomen of infants and children now requiring surgery offers not only a good prognosis but there has been a distinct and very apparent reduction in not only the incidence of complications due to infection but in the lessening of their seriousness and danger to life.

Ocular Emergencies in General Practice

F. Bruce Fralick, M.D., Ann Arbor, Michigan

Ocular emergencies constitute a very small part of the multitude of conditions those in the general practice of medicine are called upon to treat. Because of their relative infrequency, however, the physician is often at a loss as to proper approach to their management. This feeling of hesitancy is heightened by the realization that improper care may cost the patient his eyesight. It is not always possible nor always necessary to refer these patients to those especially interested in eye care, since most emergency eye conditions can and should be treated by those who first see the patient. Delay engendered by sending the patient some distance to a specialist may in itself result in a poor outcome. With such thoughts in mind, this discussion covered the emergency eye care of the common conditions seen in the general practice of medicine. Emphasis was placed upon the common mistakes made, the discussion being pointed towards a better understanding of the anatomy and physiologic functions of the eye and adnexa and the proper restoration of these anatomical and physiologic relaxations.

Preoperative and Postoperative Care

H. K. Ransom, M.D., Ann Arbor, Michigan

The risk of all operations has materially decreased during recent years and many new operations are now possible, due in large part to improvement in the methods of preparing the patient for operation and of caring for him afterwards. While the sulfa drugs, penicillin and streptomycin have received much public attention and are exceedingly important, methods for controlling many of the serious complications have not been as widely publicized. Some of these are methods for the prevention of embolism (blood clot) in the lungs, maintenance of a proper fluid intake for patients who cannot drink, and administration by vein of all the essential food elements to those who cannot eat. Changes in abdominal wounds and the materials used in their closure have permitted early rising, which is popular with patients and shortens the number of hospital days.

Early Ambulation After Operation

D. J. Leithauser, M.D., Detroit, Michigan

The rationale of early ambulation after surgery was presented from the standpoint of basic physiologic principles. Evidence was produced to show that noxious reflexes from trauma, fear, and pain induce pathologic function of vital organs which, if unduly prolonged, may result in complications. The noxious reflexes which are indirectly responsible for postoperative complications are: those to the peripheral vascular system, those to the intestinal musculature, and those to the organs of respiration, chiefly the diaphragm. The complications incident to the pathologic function induced by these reflexes are chiefly thrombosis, intestinal distention, and atelectasis.

Details of a regimen that has been used successfully to counteract the pathologic function resulting from an abdominal operation were described. The most important feature of this regimen is exercise, particularly ambulation, and the optimal time for its inauguration, if postoperative thrombosis, abdominal distention, and atelectasis are to be prevented, is immediately after operation. In addition, specific exercises reduce morbidity and materially shorten the period of convalescence.

The results of this type of treatment in a series of over 2,000 abdominal operations were reviewed. The discussion of physiology was illustrated by graphs and animated diagrams in a motion picture which also depicted method of management and rapid recovery in actual clinical cases.

During recent years, surgeons have learned that it is much safer for patients to get out of bed and engage in some activity, particularly walking, after an operation. In earlier times, it was often

thought that complications arose because the patient got out of bed too soon. Now it is known that the exact opposite is true, and that complications are more likely to occur when the patient is kept in bed for a prolonged period. Moderate exercise stimulates breathing and circulation and digestive function, and helps to prevent pneumonia, formation of blood clots, and paralysis of the intestines that sometimes develop after an operation. Besides preventing these serious complications, moderate activity initiated immediately after operation prevents weakness and enables the patient to recover much more promptly than was formerly the case. Early recovery means early return to work and thus saves both time and money.

Use of X-rays in Obstetrics

E. Walter Hall, M.D., Detroit, Michigan

The use of roentgen rays in obstetrics is definitely and properly on the increase. Failure to employ this aid to management of childbirth is largely due to lack of appreciation of the assistance that may be had from properly evaluated roentgen findings.

Information as to the condition of the pregnant uterus and its contents is often of life-saving value. Information as to the size and shape of the maternal pelvis and the fetal pelvic relationship prepares the physician for eventualities of labor enabling him to make more logical decisions as to the best procedure for the safety of mother and child.

Limitations of pelvioradiography especially in regard to dangers of diagnostic x-rays have been greatly overemphasized in medical literature, to the confusion of laymen as well as medical practitioners. The importance of experience and judgment in evaluating roentgen findings is paramount. Close teamwork between the radiologist and obstetrician is essential for good results.

Roentgen pelvimetry is rapidly taking its place in modern obstetrics along with routine pelvic measurements by physical examination. Various methods of pelvimetry should be evaluated in regard to their practical value rather than as to cost or convenience of the radiologist.

An effort to appraise various methods of pelvimery was made.

Improvements in x-ray apparatus and technique have made possible employment of x-rays for diagnostic purposes without risk of harming mother or child.

Properly made x-ray examinations properly interpreted are of great value in preventing unexpected occurrences during childbirth. The information gained is often of life-saving value and may frequently save unnecessary suffering of prolonged labor.

Neonatal Care

James L. Wilson, M.D., Ann Arbor, Michigan

The care of the newborn infant in its first two weeks of life is a large field in itself, a field which has been generally neglected. Our knowledge of the physiology of this period of life is far more limited than that at any other age and we are only now beginning to realize how completely different as a physiological mechanism the newborn animal is in almost every respect.

Practical care of the baby demands a knowledge of what is normal during this period, a knowledge difficult to acquire. At this period, symptoms which are pathological at any other time are, within certain limits, normal and the symptoms that appear are more apt to be nonspecific in their significance. One has only to think of the fact that a bleeding tendency of a slight extent is usual, that jaundice is normal, that some vomiting is normal, that irregular respirations are normal, that a certain amount of blood in the spinal fluid is seen in a high percentage of instances, that the blood sugar may be far lower than at any other age without being of significance, that moderate cyanosis is so common as to be considered often almost normal. When faced with the possibility of a pathologic condition, therefore, one has to evaluate the extent and degree of these symptoms rather than simply to determine their presence.

Only a few of the common mistakes made in caring for newborn infants can be emphasized. Attempts to prevent the initial loss of weight are often so vigorously practiced that opportunities for breast feeding may be lost. One should realize that a certain loss of weight is inevitable and normal. Fever with moderate dehydration is a common circumstance in a newborn baby. This can usually be prevented by better feeding techniques without the use of parenteral fluids which are resorted to altogether too readily.

In the present great preoccupation of the medical profession with so-called erythroblastosis, hemorrhage is apt to be forgotten. Hemorrhagic disease of the newborn is still a serious problem. Since this can be specifically treated by transfusions, one should always keep in mind that even a baby with erythroblastosis can be also suffering from hemorrhagic diseases of the newborn and that the etiology of the two conditions may be quite interdependent even though different. With a poorly functioning liver, which may often be encountered, the administration of adult blood, with its thrombin content, may frequently be necessary. Intracranial hemorrhage, when it occurs during this disease, is mostly irreversible in its effects, even though one can take a far calmer attitude towards bleeding at any other point.

New knowledge of the effect of the rhesus factor in disease has added a great deal to our knowledge, but also to our confusion. There has been a great tendency to oversimplify and overdogmatize what we now know about this disease. Babies are delivered deliberately prematurely and are transfused unnecessarily. This disease affects not only the blood but the liver, the bone marrow, and the brain of a baby. Transfusion is not a completely successful treatment in all instances, nor always logical. On the other hand, we must realize that before we knew anything about this condition, babies did survive with no treatment, or survived with transfusions not only from rhesus-negative but rhesus-positive individuals.

Convulsions during the newborn period are very frequent. Sometimes they are due to tetany, but this easily treatable condition is a rare cause. We are inclined too much, probably because of wishful thinking, to inject calcium into every baby that has a convulsion or spasm.

At present, the greatest problem that we face in the newborn period is nursery-acquired infection. Nursery infections are becoming widespread and almost endemic, even though not in the severe form as they were first described as epidemic diarrhea of the newborn. Although at present we have no clear-cut form of therapy and no sure way to prevent this disease, the medical profession must critically examine the conditions under which newborn babies are kept. They should do everything they can to improve the construction and organization of nurseries for newborn infants.

Rheumatic Fever

Herman H. Riecker, M.D., Ann Arbor, Michigan

In this discussion, emphasis was again placed upon three points regarding rheumatic fever: the essential diagnostic criteria, the avoidance of false diagnoses, and the insidious onset of the disease in many cases.

The diagnostic points consist of mitral stenosis, fibroid nodules in association with fever, malaise and anemia, migrating joint symptoms with the above, and frequently an elevated sedimentation rate. The dramatic response to salicylates is a helpful confirmatory procedure.

The minor symptoms may be of importance when occurring in certain combinations, including epistaxis, fatigue, anemia, failure to gain weight, a positive family history, low-grade fever, rapid pulse, and a history of recent respiratory tract infection.

Involvement of the heart, from the standpoint of microscopic pathology, occurs in every case and can be detected in about 80 per cent during the first attack.

There is no difficulty in diagnosis in the acute, fulminating attack, but unless mitral stenosis is present, the insidious case often presents serious diagnostic difficulties. Here the differential diagnosis includes cardiovascular asthenia, congenital heart lesion, brucellosis, and various focal infections, such as pyelitis, sinus and tonsillar disease, as well as tuberculosis and lymphoblastoma.

The diagnosis of rheumatic fever should not be made unless an unequivocal basis of evidence is present.

All structures and tissues of the heart may be involved, and in 10 per cent of children, the carditis is the only clinical manifestation and may progress in the first decade of life by a single attack to fatal termination. Carditis is reported to be present in 100 per cent of cases occurring during this period of life.

Pericarditis is the most commonly overlooked manifestation of cardiac involvement, and its detection by physical signs should be kept in mind as possibly the first evidence of activity in both latent cases and the initial attack.

Sulfonamides continue to be our best prophylactic measure for the prevention of recurrences, and small doses suffice to render most streptococcal strains nonpathogenic.

After many years of favorable clinical experi-

ence in the use of large doses of salicylates, it has now been shown in the laboratory that the salicylates do have a *specific action* in rheumatic fever. The drug should be administered by mouth, or by enema (not intravenously) in liberal dosage to all active cases.

While at present less than half the population of the state is being served, extensive expansion of case finding and proper care of all cases of rheumatic fever in Michigan is foreseen in the near future.

The service, while making severe demands upon physicians interested in the disease, is being adequately financed from the standpoint of the child by the Michigan Crippled Children Commission and the Michigan Society for Crippled Children and Disabled Adults, Inc.

Infestation With Sarcoptes Scabiei var. Hominis

Eugene A. Hand, M.D., Saginaw, Michigan

Military and civilian physicians were apprehensive during the recent great conflict that the return of our world-traveled veterans to civilian life would be followed by an increase of the tropical and other contagious diseases heretofore rare in the states. Recently the Surgeon General stated that due to counter measures and also good fortune this was untrue.

This is true for malaria, filariasis, yellow fever, cholera, intestinal parasites, and many others. As after all wars and social upheavals, there has been an increase in venereal disease, fungous infections, and especially scabies.

Scabies, the itch, or seven year itch, has long been common. The marked increase of scabies in the military and civilian population during and particularly after this war was observed by physicians in all parts of this and foreign countries. Infestations in individuals, families, and communities have been traced to furloughed and demobilized veterans.

The speaker's interest in scabies was whetted while on duty as a liaison officer with the Australian army in Perth, Western Australia. The unfortunate use of bichromate as a dye for khaki uniforms and blankets of this superb ally led to many cases of khaki or chrome dermatitis. During the early stages of this condition, the presence of general pruritis aggravated at night, the same as with scabies, made the differential diagnosis difficult.

The treatment of these conditions is diagrammatically different. The complications of dermatitis, pyodermas, and eczematization, often chronic in type, seen from treatment of scabies with sulphur and other of the antiscabetic specifics, were even more common and distressing when used by error on skin irritated by bichromate dye. It was imperative to find an easy method of finding the scabetic organism to make an accurate diagnosis, to avoid this error.

Bonomo, of Leghorn, Italy, in 1687, described the Sarcoptes scabiei var. hominis after teasing the female adult out of a scabetic burrow or vesicle on the point of a needle or pin. This has been the classic method of demonstrating the scabies insect and is so described inmost textbooks on dermatology.

This method has been likened to the difficulty of finding the pot of gold at the end of the rainbow. In the speaker's hands as well as others this has been difficult, time consuming, and impractical. A method of scraping or slicing a burrow, vesicle, or other scabetic lesion with a razor, then treating this with 10 per cent KOH before microscopic search, was devised and found most helpful. This method, which has been used by others, was described.

The symptoms, diagnosis, course, complications, and treatment of scabies were discussed. Special attention was given to the use of benzyl benzoate and other of the newer antiscabetic substances. The importance of inspecting and treating familial and other contacts to avoid reinfestations was stressed.

Lantern slides and a movie picture of the live scabies insect showing stages in the life cycle were shown.

Peritoneoscopic Studies in Epidemic Jaundice

Thomas N. Horan, M.D., Detroit, Michigan

This presentation is a description of the gross and microscopic changes in the liver in the course of jaundice. Specimens of the liver are taken by biopsy from the first days of the illness (before the jaundice has appeared) through the stage of jaundice, and into the recovery phase for as long as one or two years after the beginning of the illness. The specimens are minute but entirely adequate for microscopic study. The examination is done using local anesthesia.

A direct study of a major organ done in this

way expresses clearly the extent and nature of the damage sustained by the liver. It shows the mode and celerity of the repair process. It establishes the normal healing time, and gauges convalescence in the more protracted cases. The degree of accuracy of various liver tests can be judged, when these tests are compared, case by case, with actual changes in the liver.

Cancer of the Uterus

A. E. Catherwood, M.D., Detroit, Michigan

Cancer of the uterus assumes an important role in the life of the American family and in the interest of the medical profession.

The education of the laity to a full realization of the significance of early diagnosis and treatment, and necessity for periodic examinations, are part of the duties of the profession.

A careful pelvic examination, including a digital and speculum visualization of the cervix, is a necessity for the woman who comes for periodic check-up, in cancer detection.

Diagnosis is made by microscopic examination of tissue removed by biopsy from the site of the lesion.

At the present time, full and complete co-operation between the gynecologist, radiologist and the pathologist offers the best method of treatment for all types of cancer of the uterus, with each patient presenting her particular problem of management, if maximum benefits are to be achieved.

The treatment decided upon may be radium application, super-voltage roentgen ray therapy, surgical removal, or a combination of these procedures, depending upon the site of the lesion and the stage of the disease.

Continued follow-up observations, over a period of years, are essential if we are to benefit by experience and evolve new techniques in the management of this important disease.

DOCTORS IN GREAT BRITAIN

The 1947 edition of the *Medical Register* has recently been published (22s., post free). Particulars given in tabular form reveal that on Dec. 31, 1946, there were 76,292 names on the *Register*—nearly half as many again as in 1927, when there were 53,591. In 1946 2,237 names were added and 1,092 removed for various reasons—*British M. J.*, July 5, 1947.

ON THE RUN . . .

Treatment of patients is essentially an effort to improve their internal stability and external adaptability.

. . .

Honesty and frankness appear to rank first with patients; good medical service, sympathy, kindness and friendliness are of secondary importance.

. . .

Five per cent of patients with rheumatic heart disease and 8 per cent with congenital heart lesions develop bacterial endocarditis.

. . .

Lymphosarcoma of the small bowel is usually diffusely infiltrating and not limited to a small area of the intestine so that the mass is frequently palpated.

—*Selected* by W. S. Reveno

THE FUNDUS OCULI IN DIAGNOSIS AND PROGNOSIS

(Continued from Page 804)

comes established, the condition is practically hopeless. The diagnosis should be made from the pathologic changes in the anterior segment of the eyeball (the initially injured or its mate) before the fundus pathology has appeared, that is, a terminal phase of the disease.

Conclusions

In this presentation an attempt has been made to invade the field of internist, especially to call attention to the fact that the ophthalmologists have, with him, a most decided interest in certain medical problems. Perhaps he can be of some assistance.

Bibliography

1. Braun, R.: Deutsche med. Wchnschr., 66:527-529, (May 10) 1940.
2. Coats, G.: Roy. Lond. Ophth. Hosp. Rep., 17:440, 1907-1908.
3. Eales, H.: Ophthal. Rev., 1:41, 1882.
4. Elwyn, H.: Diseases of the Retina. Philadelphia: The Blakiston Company, 1946.
5. Von Hippel, E.: Arch. f. Ophth., 117:221, 1926.
6. Igersheimer, J.: Syphilis und Auge. 2nd Ed. Berlin: Julius Springer, 1928.
7. Koch, Wolf, Cowan, and Page: Arch. Ophthal., 26:565-584, (Oct.) 1941.
8. Leber, T.: Die Krankheiten der Netzhaut. In The Graefe-Saemisch Handbuch der gesamten Augenheilkn. 2nd Ed. Leipzig: W. Englemann, 1916.
9. Lillie, W. I.: Cardio Vascular Renal Disease. New York and London: D. Appleton Century Co., 1940 (Smith, Weiss, Lillie, Konzelmann Gault.)
10. Lucic, H.: Ophthalmology in the War Years, Vol. 1. Weiner, p. 851. Chicago: Year Book Publishers, 1946.
11. Muncaster, S. B. and Allen, H. E.: Arch. Ophthal., 21:509, 1939.
12. Nettleship, E.: Roy. Lond. Ophth. Hosp. Rep., 11:1, 1887.
13. Roenne, H.: Acta Ophth., 12:1, 1934.
14. Rochon-Duvigneaud, A.: Arch. d'Ophth., 26:175, 1906.
15. Schmidt, R.: Arch. f. Ophth., 142:1-15, 1940.
16. Schultz, J. F.: Texas State J. Med., 35:705-708, (Feb.) 1940.
17. Spaeth, E. B., and de Long, P.: Tr. Am. Acad. Ophth., 45:227, (July-August) 1941.
18. Tassman, I.: The Manifestations of Internal Diseases, 2nd ed. St. Louis: C. V. Mosby Co., 1946.
19. Woods, A.: Arch. Ophth., 18:510, 526, 1937; and Am. J. Ophth., 21:366-383, 1938.

Editorial

EIGHTY-SECOND ANNUAL SESSION

THE EIGHTY-SECOND Annual Session of the Michigan State Medical Society will be held in Grand Rapids, September 23-26, 1947. Again we visit the ideal convention city, where all activities may be held practically under one roof. It is a pleasure to meet in Grand Rapids, with its Civic Auditorium attached by subway to the headquarters hotel, The Pantlind. The Furniture City offers plenty of space. The halls need not be crowded, the exhibits will have room, and the meetings will be conviently housed.

The official call and the complete program will be presented in the August JOURNAL, but it is time our members who wish to attend begin making reservations. The scientific and technical exhibits have all been procured, and a topnotch scientific program featuring twenty-eight out-of-Michigan speakers has been arranged. Sunday and Monday, September 21-22, will be devoted to House of Delegates' meetings; the final meeting of the House of Delegates will be held Tuesday forenoon.

The Scientific Program will run from Tuesday noon to Friday noon, with twelve Section Meetings being held during the forenoon hours. Seven General Assemblies, and twenty-three Discussion Conferences will utilize all time on Tuesday, Wednesday, Thursday and Friday morning.

Alumni and fraternity dinners will be held Tuesday evening. Officers' Night will be Wednesday, and State Society Night will be Thursday.

This is a well-filled and rather ambitious program which will surpass anything we have ever held. Michigan is becoming an outstanding state, as far as medical affairs are concerned, and this year will add to our stature.

You must not miss this great incoming of medical men with their wares and their accomplishments and their ambitions.

WAGNER-MURRAY-DINGELL

PRESIDENT TRUMAN has again proposed a National Health Insurance program, and urged the Congress at least to make a start at this session. In 1945 when the President sent his message to Congress for COMPULSORY HEALTH INSURANCE, he had the stage all set; simultaneously Senators Wagner and Murray and Congressman Dingell offered another version of their bill.

The strategy used in 1945, when the President urged socialized medicine, was worked again, and on May 20, 1947, bills were introduced by Wagner, Murray, and Dingell, S-1320 and H.R.-3548. The latest bills have been entirely rewritten, and we shall present a digest as soon as possible. They provide personal health services to eligible individuals, medical services, dental services, home-nursing services, hospital services, and auxiliary services.

Medical services include general or family practice, and specialist service rendered on referral. Such services are rendered at the office, home, hospital, or elsewhere, as necessary. Dental services are in the same classification and places of service. Home-nursing consists of nursing care in the home by a registered nurse or a qualified practical nurse.

"In the provision of personal health . . . it shall be the policy to utilize . . . (1) any organized group of individuals, (2) any partnership, association or consumer co-operative, (3) any hospital or any hospital and its staff, or (4) any organization operating a voluntary health-service insurance plan or other voluntary health-service plan."

Eligibility for benefits is restricted: "If he has received (A) not less than $150 in wages during the FIRST FOUR of the LAST SIX QUARTERS PRECEDING the beginning of the benefit year, or has earned if self employed (B) not less than $50 in wages in each SIX CALENDAR QUARTERS during the first twelve of the last fourteen quarters preceding the beginning of the benefit year." You cannot benefit unless you earned at least $150 a year and a half before the beginning of the benefit year if employed, but if self-employed you must earn $50 in six three-month periods of the first three years of a three and a half-year period. This is rather complicated, but it means a self-employed person to become eligible for benefits must have been under

the plan for three and a half years. Provision is made for benefits to the needy.

"Payments to hospitals shall be based on the LEAST EXPENSIVE MULTIPLE-BED accommodations" unless the patient's condition makes private accommodations essential. Rates of payments to general medical, and dental practitioners, specialists, et cetera, shall be arrived at by regard for the annual income or its equivalent which the payments will provide. Such payments "shall be sufficient to encourage high standards in the quality of services furnished, to give assistance in their opportunities for postgraduate study, and to allow for adequate vacations."

We have found no tax provision in the bill, but "there shall be appropriated to the account for the fiscal year ending June 30, 1950, and for each year thereafter (1) sums equal to 3 per centum of all wages (earning up to $3,600) estimated to be received during the year. But there shall be appropriated to the account in the fiscal year 1949 a sum equal to 1 per centum of all wages."

THIS BILL IS AN INCOME TAX ON THE LOW INCOME GROUP. NO EXCEPTIONS ARE ALLOWED.

MICHIGAN'S TESTIMONY FOR S-545 BEFORE SENATE COMMITTEE

EDWARD F. SLADEK, M.D., of Traverse City, Chairman of the Council MSMS, was selected as Michigan's representative to testify on the Taft-Ball-Smith-Donnel Health Bill. He testified June 6, 1947.*

The health of our people can be materially benefited by the passage of S-545.

The efficacy of any national medical care program can be judged only by its value at the local level. My county of 25,000 population is typical of those rural areas which are removed from the influence of great urban centers. At this level, the operation of a voluntary prepaid medical care plan has made, over the past few years, a major contribution to the health of the entire population of my county. S-545 favors a continued development and encouragement of such voluntary plans.

Care is adequate for the people, under voluntary medical care plans, as encouraged by S-545. Such plans are desirable to the patient and satisfactory to the doctor.

S-545 can enlarge the coverage of voluntary prepaid medical care plans to include the medically indigent.

Service can be all-inclusive under a voluntary prepaid medical care plan, to cover all groups: the self-supporting, the indigent, the medically indigent, as well as those in the federal assistance categories (clients of old age assistance, aid to dependent children, aid to the blind, et cetera). A classic example is the Veterans Administration agreement with Michigan Medical Service for "home town" medical care of veterans—a plan which works equally as well in the community of 25,000 population as it does in the largest city of the state—and through which quality medical service is being rendered by a willing medical profession to the complete satisfaction of both the patients and the government.

*The full text of Dr. Sladek's statement before the Committee is published on page 756.

WHAT OF OSTEOPATHY?

OSTEOPATHY has been making gains in amount and type of practice which osteopathic practioners are allowed, or assume the right, to do. Older physicians will remember the first attempts at invasion of medical practice, how they secured entrance in one state after another, to practice a type of physical medicine. They repudiated the older field of medicine and surgery, claiming a better theory. At first they were quite popular with large classes of people who did not wish to use or have drugs prescribed for them.

The State Board Number of the *Journal of the American Medical Association* May 17, 1947, reports examinations in fifteen states, where osteopathic graduates are allowed to take the Medical Board examination: Colorado, Connecticut, Delaware, District of Columbia, Indiana, Massachusetts, Nebraska, New Hampshire, New York, New Jersey, Ohio, Oregon, Texas, Virginia, Wisconsin and Wyoming. In all, 802 osteopaths have been licensed by examination in these states in 1941-1946, and 152 by reciprocity or endorsement. The schedules of practice under these acts differ somewhat. In Connecticut, Indiana, New York, New Hampshire, Nebraska, they may practice medicine and surgery; in Colorado, medicine; in others, osteopathy.

In Michigan, as in many other states, osteopaths have assumed the practice of medicine and surgery and obstetrics under their own practice laws. During the years various governmental and industrial groups have recognized them for services, and

during the war, owing to an actual shortage of doctors of medicine, created by the military chiefs of this country who demanded M.D.'s and not D.O.'s practice, osteopaths extended their privileges. The Selective Service accentuated the condition by exempting osteopaths and osteopathic students from the draft, but would not grant the same privilege to M.D.'s. Doctors of Medicine in large numbers were called from small towns, rural areas, and many of our countries became shorthanded. These could be replaced only by osteopaths, for no other practitioners were available.

Only one result could be forthcoming. General and rural practice has largely been pre-empted by young, ambitious cultists ready to seize new opportunities, ready to make home calls and night calls where the older doctor of medicine, worn out by the terrific grind of service to double his ordinary round of patients, could not respond.

The result! We have a growing situation of two overlapping groups trying to care for the public. The best thought and efforts of our membership are needed to solve the problem presented.

POSTOPERATIVE PULMONARY EMBOLISM*

APPROXIMATELY ONE out of every 1,100 postoperative surgical patients dies from fatal pulmonary embolism. Statistics supporting this conclusion are derived from several hundred thousand surgical patients surveyed in large reputable surgical clinics in this country. While this death rate due to thrombo-embolic pathologic conditions is not enormous, yet it merits real consideration toward its reduction.

Treatment designed to combat this type of surgical catastrophe roughly falls under one of three plans. The first is largely preventive. Under this heading comes the perfect preparation of the patient for surgery. As excellent physical condition as possible should be achieved and all of the various elements of the blood brought up to normalcy. The operation itself should be done gently, meticulously and with complete hemostasis. Nonabsorbable sutures should be used wherever possible. Postoperatively the patient should be encouraged to exercise as much as possible, to change his position in bed frequently, to see there is no type of pressure in the popliteal space by bed arrangement, to practice deep breathing exercises and perhaps stay away from tobacco both preoperatively and postoperatively because of the vasospastic effect. Ambulation as early as possible for each individual case should be strongly encouraged inasmuch as there are definite statistics showing the greatly decreased thrombo-embolic phenomena where early ambulation is practiced.

Under the second plan of treatment we have the anticoagulants. Barker at the Mayo Clinic has conclusively shown that thrombo-embolism can be decreased almost to zero by intelligent use of dicoumarol. Bauer has obtained somewhat comparable results from heparin.

Definite pitfalls exist in this type of treatment however in the matter of varying sensitivity of patients to these drugs. Where the sensitivity is great, prothrombin and coagulation times may be so lengthened that resultant wound and internal hemorrhages can occur. In the case of dicoumarol if very careful observation of the patient is practiced and the daily prothrombin rate is kept between 30 and 40 per cent of normal, then excellent results can usually be obtained.

The third plan of treatment entails the various vein ligations advocated by such men as Allen, Coleman, Detakats and others. While excellent results are obtained here, it must be remembered that the greatest percentage of thrombo-embolic deaths occur without any warning whatever; hence it is impossible in the majority of cases to determine when the ligations should be done. These ligations usually are done in the superficial femoral vein just distal to the profunda. However, ligations can be carried out in the common femoral, iliac or even the vena cava. Many of these particular procedures are major operations in themselves, and it is our opinion that they will not stand the test of time.

In summary, we favor the excellent preparation of the patient, careful, gentle, meticulous surgery, early exercise and ambulation with the use of dicoumarol therapy in the selected operations where thrombo-embolism is most apt to develop. Such operations are those on the uterus, bladder, prostate, rectum, colon, gangrenous appendices, biliary tract and hernias in obese subjects.

RUSSEL L. MUSTARD, M.D.

*This abstract from the first annual meeting of the Michigan Postgraduate Clinical Institute was so important that we are using it as a Scientific Editorial and have asked Dr. Mustard to write a more extensive paper on the subject, which will appear in a future number of THE JOURNAL.

THE 82nd ANNUAL SESSION MICHIGAN STATE MEDICAL SOCIETY

Pantlind Hotel-Civic Auditorium, Grand Rapids, September 23-26, 1947

INFORMATION

Registration, Tuesday noon to Friday noon, September 23-26, exhibit floor, Civic Auditorium, Grand Rapids.

No registration fee to MSMS members.

Admission by badge only.

Postgraduate Credits given to every member who attends MSMS Annual Session.

Seven General Assemblies—Twelve Sectional meetings—twenty-three Discussion Conferences on September 23-24-25-26.

Public Meeting. The Fourth General Assembly, Wednesday, September 24, 8:30 p.m.—Officers' Night—will be open to the public. Invite your patients and friends to hear an internationally famous personage scheduled for this program.

Papers will begin and end on time. This scientific meeting will feature by-the-clock promptness and regularity.

House of Delegates, MSMS, convenes Sunday, September 21 at 2:00 p.m., Ballroom, Pantlind Hotel; it will hold two meetings on Monday, September 22, at 10:00 a.m. and at 8:00 p.m., and conclude with a breakfast and meeting Tuesday, September 23, at 8:00 a.m.

One hundred four technical exhibits and a score of scientific exhibits will contain much of interest and value. Intermissions to view the exhibits have been arranged.

Please register at every booth.

Burton R. Corbus, M.D., Grand Rapids, is General Chairman of the Grand Rapids Committee on Arrangements for the 1947 MSMS Annual Session.

Committee on Scientific Exhibits—J. W. Logie, M.D., Grand Rapids, and John M. Wellman, M.D., Lansing.

Press Relations Committee for the scientific session—C. A. Payne, M.D., Chairman, assisted by G. T. Aitken, M.D., and J. R. Brink, M.D., all of Grand Rapids.

Parking—Do not park your car on the street. Convention parking near the Civic Auditorium will be marked off with suitable sidewalk signs. The Grand Rapids Police Department will issue courtesy cards (at Registration Desk) for out-of-town autos, which give parking privileges but do not apply to metered spaces. Nearby parking lots are available, as well as convenient indoor parking facilities. The indoor parking rate at the Pantlind Garage is $1.00 for twenty-four hours. This is close to the Pantlind Hotel.

The Woman's Auxiliary to the Michigan State Medical Society will present an attractive social and business program to which the wife of every MSMS member is cordially invited.

GENERAL ASSEMBLIES

Tentative Program

All General Assemblies will be held in the Black and Silver Ballroom of the Civic Auditorium, except the Fourth Assembly of Wednesday evening, September 24, which will be held in the Ballrooms of the Pantlind Hotel.

First General Assembly

TUESDAY, SEPTEMBER 23 *(afternoon)*

P.M.

1:40 *Allen O. Whipple, M.D., New York,* Emeritus Valentine Mott Professor of Surgery, Columbia University, Clinical Director, Memorial Hospital, New York City. "The Early Diagnosis of Pancreative and Ampullary Growths, with an Evaluation of Surgical Therapy."

2:00 *Andrew C. Ivy, M.D., Chicago,* Vice President, University of Illinois. "The Diagnosis of Jaundice from a Therapeutic Viewpoint."

2:20 *Wendell G. Scott, M.D., St. Louis, Mo.,* "The Investigation of Low Back Pain by Radiographic Methods."

3:45 *Louis Schwartz, M.D., Washington, D. C.,* Medical Director (Retired), Consultant to Officers of Dermatology, U.S.P.H.S. "Diagnosis, Prevention and Treatment of Occupational Dermatitis."

4:05 *C. B. Lull, M.D., Philadelphia,* Director, Division of Obstetrics and Gynecology, Pennsylvania Hospital, Consultant Obstetrician and Gynecologist to the Philadelphia General Hospital, Chief of Staff and Consultant to the Delaware County Hospital. "The Changes and Improvements in Obstetric Practice During the Past Twenty-Five Years."

Second General Assembly

WEDNESDAY, SEPTEMBER 24 *(morning)*

A.M.

9:30 *Frederic E. B. Foley, M.D., St. Paul, Minn.* "The Part of the General Practitioner in the Management of Vesical Neck Obstruction."

9:50 *Harry Gold, M.D., New York,* Associate Professor of Pharmacology at Cornell University Medical School, Attending Cardiologist at the Beth Israel Hospital and at the Hospital for Joint Diseases, New York. "Management of the Failing Heart."

11:10 *Russell L. Cecil, M.D., New York,* Professor of Clinical Medicine, Cornell University Medical College, Visiting Physician Bellevue Hospital, Consulting Physician New York and Veterans' Hospitals. "Chronic Arthritis."

11:30 *George M. Curtis, M.D., Columbus, Ohio.* "Surgery of the Spleen."

Third General Assembly

WEDNESDAY, SEPTEMBER 24 *(afternoon)*

P.M.

1:40 *A. D. Campbell, M.D., Montreal, Canada.* "Certain Aspects of Vaginal Surgery."

2:00 *John R. Lindsay, M.D., Chicago,* Professor of Otolaryngology, University of Chicago. "Vertigo: Differential Diagnosis and Treatment."

2:20 *R. V. Platou, M.D., New Orleans, La.* "The Tuberculous Child."

3:45 *Reynold A. Jensen, M.D., Minneapolis.* "The Physician and the Child."

4:05 *C. F. Dixon, M.D., Rochester, Minn.* "Carcinoma of the Colon and its Management."

Sixth General Assembly

THURSDAY, SEPTEMBER 25 *(afternoon)*

P.M.

1:40 *Paul A. O'Leary, M.D., Rochester, Minn.,* "The Use of Penicillin in the Treatment of Syphilis in General Practice."

2:00 *L. Emmett Holt, Jr., M.D., New York.* "The Treatment of Infantile Diarrhea."

2:20 *R. L. Haden, M.D., Cleveland, Ohio.* "Gout."

3:45 *Joseph D. Aronson, M.D., Philadelphia.* "The Role of BCG Vaccine in the Control of Tuberculosis."

4:05 *S. W. Harrington, M.D., Rochester, Minn.* "Cancer of the Breast."

Fourth General Assembly

WEDNESDAY, SEPTEMBER 24 *(evening)*

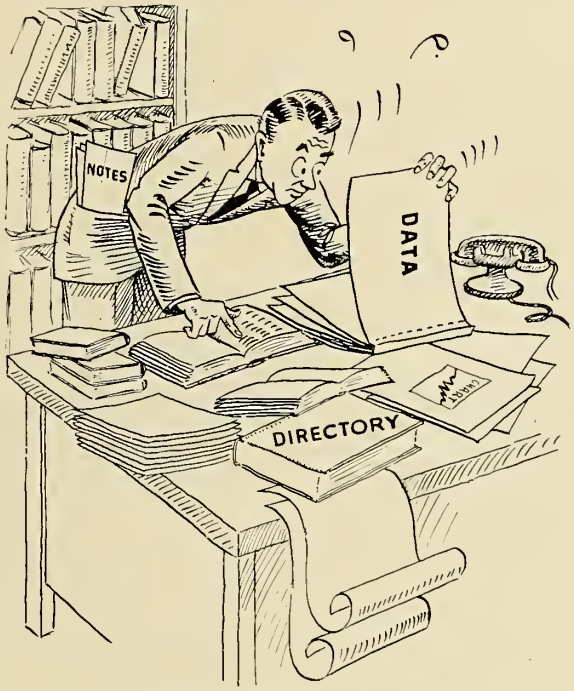
Public Meeting

P.M.

8:30 OFFICERS' NIGHT. Presidential Address and Induction of New President

Biddle Oration

Rear Admiral C. A. Swanson, MC, USN, The Surgeon General, Washington, D. C., "Atomic Radiation and Its Medical Implications."



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THURSDAY, SEPTEMBER 25 *(evening)*

STATE SOCIETY NIGHT

P.M.

10:00 Dancing for MSMS members and their ladies. Ballroom, Pantlind Hotel, Grand Rapids.

Fifth General Assembly

THURSDAY, SEPTEMBER 25 *(morning)*

A.M.

9:30 *R. H. Williams, M.D., Boston.* "Comparison of Chemical and Physical Methods of Treating Thyrotoxicosis."

9:50 *C. S. O'Brien, M.D., Iowa City, Iowa.* "Senile Cataract from the Standpoint of the General Practitioner."

11:10 *Frank E. Whitacre, M.D., Memphis, Tenn.* "The Diagnosis and Treatment of Ectopic Pregnancy."

11:30 *Michael DeBakey, M.D., New Orleans.* "Therapeutic Application of Hemometakinesia in Peripheral Vascular Disturbances."

Seventh General Assembly

FRIDAY, SEPTEMBER 26 *(morning)*

A.M.

9:30 *Clement A. Smith, M.D., Boston.* "The Potentialities and Limitations of Prenatal Pediatrics."

9:50 *Alan R. Moritz, M.D., Boston.* "When and Why Should the State Compel the Performance of an Official Autopsy?"

11:10 *W. Wayne Babcock, M.D., Philadelphia.* "Closure of Abdominal Fistula."

11:30 *W. E. Herrell, M.D., Rochester, Minn.* "The Present Status of Sulfonamide and Antibiotic Therapy."

General Assemblies end at 11:50 a.m.

SECTION MEETINGS

Tentative Program

Tuesday, September 23, 12:00 noon to 1:30 p.m.

(luncheon meetings)

1. *Dermatology,* Room 222, Pantlind Hotel
   Louis Schwartz, M.D., Washington, D. C., "Dermatitis from Wearing Apparel."
2. *Radiology,* Sadler Lounge, Pantlind Hotel
   W. G. Scott, M.D., St. Louis, Mo. "Prolapses of the Gastric Mucosa as a cause of Gastrointestinal Symptoms."

Wednesday, September 24, 12:00 noon to 1:30 p.m.

(luncheon meetings)

3. *Urology,* Room 322, Pantlind Hotel
   Frederic E. B. Foley, M.D., St. Paul, Minn. "An Artificial Sphincter—a New Device and Operation for Control of Urinary Incontinence and Nocturnal Enuresis."
4. *Pediatrics,* Sadler Lounge, Pantlind Hotel.
   R. V. Platou, M.D., New Orleans, La. "Management of Infantile Congenital Syphilis."
5. *Surgery,* Ballroom, Pantlind Hotel
   C. F. Dixon, M.D., Rochester, Minn. "Importance of Preoperative and Postoperative Care in Intestinal Surgery."
   George M. Curtis, M.D., Columbus, Ohio—Discussant.
6. *Otolaryngology,* Room 222, Pantlind Hotel
   John R. Lindsay, M.D., Chicago. "The Significance of Postural Vertigo in Otoneurological Diagnosis."

Thursday, September 25, 12:00 noon to 1:30 p.m.

(luncheon meetings)

7. *Anesthesia,* Room 322, Pantlind Hotel
   Round Table on "Economic Problems in Anesthesiology."
   R. J. Armstrong, M.D., Kalamazoo, Mich., Leader.
8. *Ophthalmology,* Room 222, Pantlind Hotel
   C. S. O'Brien, M.D., Iowa City, Iowa. "Surgery of the Extraocular Muscles."
9. *Medicine,* Furniture Room, Pantlind Hotel.
   H. M. Pollard, M.D., Ann Arbor. "Recent Developments in the Management of Peptic Ulcer."
10. *Gynecology-Obstetrics,* Schubert Room, Pantlind Hotel
    Harold C. Mack, M.D., Detroit. "Changing Trends in Cesarean Section."
11. *General Practice,* Ballroom, Pantlind Hotel.
    R. L. Cecil, M.D., New York. "Unusual Forms of Rheumatic Pain."

Friday, September 26, 12:00 noon to 1:30 p.m.

(luncheon meetings)

12. *Pathology,* Room 222, Pantlind Hotel
    F. Roland Allaben, LL.B., City Attorney, City of Grand Rapids. "The Doctor in Court."
    Alan R. Moritz, M.D., Boston—Discussant.

Committee Reports

ANNUAL REPORT OF COMMISSION ON HEALTH CARE—1946-47

The experience of the Commission on Health Care during the year 1946-1947 leads increasingly to the conclusion that the activities of the State Medical Society relating to irregular practice of all types, need to put forward continuous effort from the standpoint of legislation and law enforcement. Beyond this we are increasingly convinced that the best results as relating to the problems created by so-called "doctors" (not M.D. and D.D.S.) in the health field, is more and better care of the public by the regular health professions.

There is evidence that good health care can be markedly increased by the careful development of "Medical Associates." To this end effort has been put forth this year. We have been handicapped by lack of funds, but more have been forthcoming recently, and at least for a time a full-time secretary has been assigned to the Commission.

Committees are working on the following divisions:

The Division of Dental Associates
The Division of Dietetics
The Division of Medical Secretaries and Librarians
The Division of Nursing
The Division of Clinical Laboratory Assistants
The Division of Physical Medicine and Occupational Therapeutics
The Division of Ophthalmic Associates
The Division of Orthopedics and Dermatology
The Division of X-Ray Technicians
The Division of Clinical Psychology
The Division of Medical and Surgical Art and Photography
The Division of Associates to Hospital Administrators
The Division of Economics of the Health Services
The Division of Pharmacy
The Division of Public Health (and Veterinarian Services).

It seems apparent that for every doctor of medicine and dentist in the United States, about nine others are required somewhere in the health field to care for health needs. These are auxiliary to the doctors of medicine and dentists, and essential to the distribution of medical care. With 130,000 physicians, and 70,000 dentists, that means 1,800,000 associates to the doctors of medicine and the dentists. At only $200.00 per month, this represents over four billion dollars needed annually, to provide for those who are necessary if the medical and dental professions are to distribute medical care efficiently. Our estimate is very low; five billion would come closer to it.

These considerations call to our attention the following points:

1. The big business in terms of money represented in the care of the people through the health services.

2. The stake that the government has in it from the standpoint of public health.

3. The temptation held out to politicians in wanting to control such vast resources.

4. The possibilities of political mal-use of medical Associates, if left to politics alone.

5. The need, therefore, of our seeing the whole picture and setting it up to be administered by the health professions who ought to be able to direct it efficiently.

6. The need of our being in position to place in the hands of our representatives in Congress, organization detail to implement such legislation in the interests of the people, such as the Taft bill.

7. The need of a system, set up and managed by the health professions, into which all necessary government

health activities can enter on a basis not unlike the co-operation of the government with Michigan Medical Service Veterans' care.

8. The need for the medical profession to provide something better than we would expect compulsory health insurance to be or to expect the people to vote for compulsory health insurance.

The United States government is our government, too. Let us place ways and means for health care, as we think it should be, in the hands of our representatives in Congress, so that both they and the people may vote for it.

Respectfully submitted,
Ralph H. Pino, M.D., *Chairman*
H. M. Pollard, M.D.
B. R. Corbus, M.D.
F. H. Drummond, M.D.
H. A. Kemp, M.D.

ANNUAL REPORT OF COMMITTEE ON DISTRIBUTION OF MEDICAL CARE—1946-47

The committee met in Detroit at the David Whitney House on December 11, 1946, for the purpose of studying and making recommendations on present and future problems.

The problem of collection of fees for emergency hospitalization services to veterans with non-service connected disability was discussed, and it was decided to appoint a subcommittee who should act as an advisory committee to assist the Michigan Office of Veterans Affairs in this matter. Dr. E. M. Vardon was later appointed as the committee.

Dr. Carleton Dean explained in detail to our committee the need for extended physical restoration programs and for legislative aid to afflicted adults. It was recommended that Dr. Dean be placed on a subcommittee of the Michigan State Medical Society Commission on Health Care and also that it be recommended to The Council of the Michigan State Medical Society that it urge creation of physical restoration courses in the universities.

Respectfully submitted,
C. W. Colwell, M.D., *Chairman*
S. W. Insley, M.D., *Vice Chairman*
W. W. Babcock, M.D.
R. H. Baker, M.D.
George Curry, M.D.
H. F. Dibble, M.D.
O. K. Engelke, M.D.
C. E. Lemen, M.D.
R. H. Pino, M.D.
E. C. Sites, M.D.
E. C. Texter, M.D.
E. M. Vardon, M.D.
W. R. Young, M.D.

ANNUAL REPORT OF MEDICAL LEGAL COMMITTEE—1946-47

No meeting of the Medical Legal Committee has been held during the past year. As has been the custom for several years, the function of this committee has been to act in an advisory capacity only.

Only one physician has consulted the chairman of the committee about a threatened malpractice suit. This man did not carry any form of malpractice insurance, and all we could do was to advise him that he should employ an attorney with experience in such cases and await results.

It is again reitcrated that every physician in the state should notify the Executive Secretary of the Michigan State Medical Society at once, if a suit is threatened.

Respectfully submitted,
S. W. Donaldson, M.D., *Chairman*
F. A. Mercer, M.D.
W. B. Mitchell, M.D.
W. J. Stapleton, Jr., M.D.

ANNUAL REPORT OF PREVENTIVE MEDICINE COMMITTEE—1946-47

In the year just passed the Committee on Preventive Medicine has held two meetings at which the activities of its advisory groups were thoroughly discussed and indicated recommendations passed on to The Council of the Society.

Prominent in these discussions were:

1. The question of further extension of the effort of the Scientific Radio Committee in the direction of broader coverage;
2. Progress made by the Iodized Salt Committee towards stimulating renewed lay and medical interest in this valuable preventive measure;
3. Planning of a long-range investigation of hypertension by the Committee on Degenerative Diseases;
4. Recommendations for a standard procedure to be followed in the reporting, prevention and management of infectious diarrhea in the newborn;
5. Follow-up studies by the Child Welfare Committee of the survey conducted in co-operation with the Academy of Pediatrics; and
6. A discussion of present and future activities of the Rheumatic Fever Control Committee.

The Committees on Cancer Control, Venereal Disease Control, Mental Hygiene, Maternal Welfare and Industrial Health have all been active in carrying out programs previously set up.

Reports of all advisory committees appearing in these pages offer but brief testimony of the effort and devotion in the interest of the public and the Society.

As in former years, the co-operation of the State Health Department under Commissioner Wm. DeKleine, was ever available and always helpful.

Respectfully submitted,
Wm. S. Reveno, M.D., *Chairman*
A. E. Catherwood, M.D.
B. R. Corpus, M.D.
H. H. Cummings, M.D.
William DeKleine, M.D.
H. A. Luce, M.D.
K. E. Markuson, M.D.
R. D. McClure, M.D.
R. M. McKean, M.D.
N. F. Miller, M.D.
H. M. Pollard, M.D.
L. W. Shaffer, M.D.
Frank VanSchoick, M.D.
W. R. Vis, M.D.

ANNUAL REPORT OF CANCER CONTROL COMMITTEE—1946-47

The Cancer Control Committee was enlarged this year by President Hyland through appointment of the members of the Professional Executive Committee of the American Cancer Society, Michigan Division, and of representatives of the Michigan Department of Health to the Committee as formerly constituted. This made a committee of twenty-five members, and, thus, for the first time in Michigan, one committee represents all organizations in the state interested in the cancer problem. One member of the committee was appointed secretary on a full-time salary basis, with offices in Ann Arbor. Secretarial and other committee expenses were met by contributions from the American Cancer Society, Michigan Division, Michigan Department of Health, and the Michigan State Medical Society.

Four meetings of the Cancer Control Committee were held during the year; one each in October, December, April and May. At the first meeting, three subcommittees were appointed and assigned definite duties relating to the cancer control program in the state. An outline of their accomplishments follows:

The subcommittee on Education studied the problem of lay and professional education, one result of which was the formation of a Speakers' Bureau composed of

sixty-two physicians, well distributed over the lower peninsula. Members of this Bureau have spoken at almost forty lay meetings arranged through the secretary's office. Many other similar meetings were held by arrangement through the office of the Michigan Division, American Cancer Society, which were not reported to the secretary's office.

One of the major professional education undertakings was the distribution of the Michigan Cancer Bulletin to all members of the Michigan State Medical Society. The cost of this bulletin and its distribution was met by the Michigan Department of Health. This series of bulletins, adapted from the Illinois Cancer Bulletin, consists of thirteen numbers, each number discussing the diagnosis and treatment of one or more major types of cancer. The information in these bulletins will bring down to date the *Cancer Manual* for Physicians published jointly by the Michigan State Medical Society and the Michigan Department of Health about four years ago.

The subcommittee on Education has edited a series of fourteen newspaper articles on cancer for the layman, which were distributed throughout the state by the Michigan Division of the American Cancer Society.

Each county medical society has been urged to hold at least one cancer meeting during the year and, wherever possible, to have a cancer teaching day for the physicians of a county or district. Five such meetings are known to have been held during the year: two in Battle Creek, and one each in Flint, Mt. Pleasant, and Benton Harbor. Others are scheduled for later in the year.

Under the direction of the subcommittee on Education, a meeting was held in Marquette in June for chairmen of cancer committees and health officers of the Upper Peninsula to discuss education and other cancer control problems in that area. Three committee members and a representative of the Michigan Department of Health attended this meeting.

During the year, four radio broadcasts were given by members of the subcommittee on Education over the University of Michigan station and affiliated stations.

The Dean of the School of Public Health of the University of Michigan has been urged to place more emphasis on the subject of cancer in the training of professional public health personnel; also, to hold an in-service seminar or institute of two or more days' duration for professional health workers at a convenient time in the near future. A favorable reaction was obtained toward both of these suggestions.

The subcommittee on Ways and Means held one meeting during the year to survey the extent of existing funds for cancer work, and to discuss the future collection and disbursement of funds for cancer control purposes in Michigan.

The Fact-Finding subcommittee organized a statewide cancer survey, the field work of which was carried out during July and August by trained third-year medical students. This survey consisted of two parts: (1) the collection of comparable data from each hospital of 25 beds or more, showing bed capacity, facilities for diagnosis and treatment of cancer patients, the number of such patients cared for, and similar data; (2) an intensive pilot survey of four local areas—Hillsdale County, Kent County, the district of Antrim, Charlevoix and Emmet counties, and the district of Baraga, Houghton and Keweenaw Counties—was carried out on invitation of the medical societies in each area. In these surveys, data regarding every cancer patient seen by each physician or cared for in the hospitals in these four areas in 1946 were recorded on special blanks so that statistical analyses could be made of the information obtained. These studies, which should give valuable information on the incidence and prevalence of cancer in these local areas, and indirectly in the state as a whole, will not be completed for several months.

These surveys have been endorsed by the Michigan Hospital Association, Michigan State Nurses Association, and the Michigan State Dental Society.

At each meeting of the Cancer Control Committee, in addition to considering the many problems relating to the control of cancer in Michigan, an invited speaker has discussed some special cancer subject. These speakers and their subjects have been as follows:

Lewis C. Robbins, M.D., Cancer Consultant, U. S. Public Health Service, Chicago.
"The State-Aid Cancer Program of the U. S. Public Health Service."

R. L. Mason, M.D., American Cancer Society, New York.
"The American Cancer Society Program."

Paul R. Gerhardt, M.D., Director, Cancer Control Division, West Virginia State Department of Health, Charleston.
"The West Virginia Cancer Control Program."

W. E. Murray, D.Sc., Executive Director, Detroit Cancer Institute, Detroit.
"What's New in Cancer Research."

J. Ernest Ayre, M.D., Royal Victoria Hospital, Montreal, Quebec.
"The Cell Smear Technique in Cancer Diagnosis."

These special discussions have been of material help to committee members in formulating plans for the cancer control program in this state. These speakers came at the expense of the organization they represented. Or their expenses were paid by the Michigan Department of Health.

The Secretary's office has answered many inquiries from Michigan and other states regarding the cancer program. The Committee has given advice and helpful suggestions to several local medical organizations in the state regarding the organization and functioning of cancer detection centers.

Advantage has been taken of all opportunities to encourage added emphasis on the cancer control problem among professional and lay organizations throughout the state.

The Committee urges a continuation and expansion of this broad program of education and service in the cancer field during the coming year.

Respectfully submitted,

N. F. Miller, M.D., *Chairman*
W. A. Hyland, M.D., *Ex officio*
F. A. Coller, M.D., *Advisor*
F. L. Rector, M.D., *Secretary*
M. R. Burnell, M.D.
D. C. Burns, M.D.
E. I. Carr, M.D.
William DeKleine, M.D.
S. E. Gould, M.D.
C. K. Hasley, M.D.
L. E. Holly, M.D.
A. A. Humphrey, M.D.
C. H. Keene, M.D.
O. W. Lohr, M.D.
H. F. Mattson, M.D.
W. D. Mayer, M.D.
A. B. McGraw, M.D.
H. M. Nelson, M.D.
H. M. Pollard, M.D.
H. W. Porter, M.D.
H. R. Prentice, M.D.
W. W. Sawyer, M.D.
B. F. Sowers, M.D.
H. J. VandenBerg, M.D.
H. L. Weitz, M.D.
Bernie Luck, D.D.S.

ANNUAL REPORT OF CHILD WELFARE COMMITTEE, 1946-47

The Child Welfare Committee has had only one formal meeting this year, but the chairman has met informally with small groups many times while attending other meetings.

The entire activity of the committee has been devoted to the co-operative study with the American Academy of Pediatrics and the Society for Crippled Children and Disabled Adults. This Study of Child Health Service has been completed in Michigan with a high degree of success. A few statistics will attest to this statement.

80% return of all Michigan State Medical Society members.
80% return of all Michigan State Dental Society members.
99% return of all pediatricians.
95% return of all health jurisdictions.
80% return of all hospital beds.

This represents a far better than average return.

The coming year the committee with others will be charged with processing the data accumulated in the study and publicizing the findings. To this end the Society for Crippled Children and Disabled Adults already has underwritten the estimated cost of publication of this material.

Respectfully submitted,

Frank VanSchoick, M.D., *Chairman*
R. M. Kempton, M.D., *Vice Chairman*
Moses Cooperstock, M.D.
Carleton Dean, M.D.
Campbell Harvey, M.D.
A. M. Hill, M.D.
J. L. Law, M.D.
A. L. Richardson, M.D.
L. P. Sonda, M.D.
Kenneth Wells, M.D.

ANNUAL REPORT OF COMMITTEE ON VENEREAL DISEASE CONTROL—1946-47

Five regular meetings and a special meeting of the Venereal Disease Control Committee were held during the past year. A special meeting was held with representatives of the Michigan Society of Pathologists at the Book-Cadillac Hotel on Wednesday evening, March 5, 1947.

At the first meeting October 27, 1946, means of improving contact-finding in cases of infectious venereal disease were discussed. A subcommittee was appointed to study and report on the Mississippi plan of "self interview." The status of special dispensation for marriage certification was discussed and a subcommittee appointed to draw up new regulations. Dr. G. D. Cummings reported on the status of complement fixation and quantitative Kahn tests. He hoped to make them available, at least on request.

At the meeting of December 15, 1946, the problem of contact finding was further discussed. It was hoped that a special study of the Mississippi "self interview" plan might be tried in Ingham County. It was suggested that the problem of case finding in infectious venereal disease be called to the county medical society's attention through the Secretary's Letter.

At the meeting of January 26, 1947, the report of the subcommittee on requirements for special dispensation was reviewed, discussed and approved. These requirements along with reprints of the committee's articles on "Serologic Interpretation" and "Use of Penicillin in Syphilis" were to be mailed to each physician through the Michigan Health Department. The subcommittee on reporting of laboratory evidence of venereal disease by private laboratories reported recommendations.

At the joint meeting with the Michigan Society of Pathologists held in Detroit, March 5, 1947, the problem of private laboratories was discussed, reporting at some length. The general attitude was favorable to such reporting. However, since only three pathologists were present, Dr. Breakey and Dr. Stiles were appointed by the Chair to attend the next meeting of the Society of Michigan Pathologists to be held in Saginaw, May 31, 1947.

At the last meeting of the committee held May 18, 1947, Dr. H. H. Cummings was present. The main items for discussion were medical and lay educational programs in venereal disease. Revival of metal posters for toilets, radio programs and the activity of the Public Relations Committee on sex education records for use in high schools was discussed. The recommendation that a one-day program be held for education of physicians in the modern diagnosis and treatment of venereal disease was unanimously approved.

A meeting is to be held in Muskegon on Saturday, July 26, 1947, with the committee members as the guests of Dr. Ray H. Holmes.

Respectfully submitted,

L. W. Shaffer, M.D., *Chairman*
R. S. Breakey, M.D., *Vice Chairman*
K. A. Alcorn, M.D.
A. C. Curtis, M.D.
Ruth Herrick, M.D.
M. J. Holdsworth, M.D.
R. H. Holmes, M.D.
H. L. Keim, M.D.
E. S. Parmenter, M.D.
Frank Stiles, M.D.

ANNUAL REPORT OF MENTAL HYGIENE COMMITTEE, 1946-47

The Committee has taken very seriously its duties and responsibilities and has held a number of well-attended meetings.

The present-day emphasis on psychiatry has been of deep concern to the Committee. We feel that in this present era the pendulum has swung too far away from the center of resourceful human personalities. Too much faith has been put into academic solutions, at times of bizarre pattern. Too little stress has been placed on the affirmative approach that has as its goal the development within the individual of abilities to face realities and to develop a plan of living and an objective in life.

Your Committee has been concerned with the tendency of what might be classed as charlatanry. It has frequently come to our attention that individuals are taking advantage of the present-day misunderstanding of psychiatry and commercializing it, individuals who are neither adequately medically trained or, even worse, have not the properly adjusted type of personality to help those who need emotional guidance and direction. The medical practice act in our state has no screening capacity for eliminating those unfit to treat "the person in the body."

The Committee formulated a list of facts regarding mental health that it was felt desirable to make in order that the position of the Michigan State Medical Society in this field might be established.

These statements were approved by the Executive Committee of MSMS and as such stand as a record of the Society's position.

During the year The Journal has published under the sponsorship of this Committee and under the caption "STOP—LOOW—LISTEN" several columns of pithy statements. The purpose was to emphasize psychiatric facts of importance to the whole profession. Space does not allow repetition of these statements except to emphasize the caption: "STOP telling the patient there

is nothing wrong with him—go home and forget it." "LOOK for the facts as the patient sees them." "LISTEN attentively and patiently to the patient's story."

During the year your Committee took active part in such legislation as concerned Mental Health subjects.

The Committee approved the establishment of a section on neuropsychiatry by the State Society, and by this action automatically recommends the same to the House of Delegates for approval at this meeting.

The Committee would like to emphasize an action taken by it and approved by the Executive Committee, to wit: that all general hospitals of over 200 bed capacity should have a division for psychosomatic and early potential psychiatric cases adequately staffed and equipped—again and again calling attention to the importance of early diagnosis and treatment.

During the year the Committee approved, and the Executive Committee of MSMS endorsed, the summary of Michigan's mental health needs as outlined by Charles A. Zeller, M.D., State Director of Mental Health.

Your Committee requested space at the annual meeting where an advisory clinic could be established, to which physicians remote from psychiatric aid might bring their problems regarding patients who were making poor adjustments or, if desirable, might bring medically indigent patients for evaluation and advice. The Executive Committee, while approving the idea, did not see fit to allocate the space.

You will note that the Committee, in its modesty, has not tried to lay out a world-wide program to solve the emotional and political ills of this mundane sphere. However, it believes that a better understanding of human behavior and social relations, as understood by psychiatrists, can make a worth-while contribution to our hoped-for goals.

Respectfully submitted,

H. A. Luce, M.D., *Chairman*
R. G. Brain, M.D.
F. P. Currier, M.D.
M. H. Hoffmann, M.D.
R. A. Morter, M.D.
R. W. Waggoner, M.D.
O. R. Yoder, M.D.

ANNUAL REPORT OF COMMITTEE ON IODIZED SALT—1946-47

The committee held one formal meeting on January 24, 1947, at the Wayne County Medical Society Building. At this meeting a report of the National Study Committee on endemic goiter was made. A pamphlet distributed by the Michigan State College entitled "Are You Using Iodized Salt?" was discussed. The results of a 1943 survey of the number of thyroid operations in seven Michigan hospitals was given. A motion requesting another survey to determine the incidence of goiter among school children was passed. This would be particularly valuable because of the previous surveys made in the Michigan schools.

Dr. Kimball and several others vitally interested in the iodized salt problems have introduced to the House of Representatives HR No. 2717 relative to the iodization of table salt. The congressional committee is to hear this bill in the near future, and we are to testify before this committee in an attempt to pass this very important bill.

Respectfully submitted,

Roy D. McClure, M.D., *Chairman*
B. E. Brush, M.D.
L. W. Gerstner, M.D.
D. E. Lichty, M.D.
R. J. Moehlig, M.D.
C. A. Payne, M.D.
L. E. Showalter, M.D.
H. A. Towsley, M.D.

ANNUAL REPORT OF COMMITTEE ON HEART AND DEGENERATIVE DISEASES—1946-47

Two meetings of the Heart and Degenerative Diseases Committee were held during the past year. Since rheumatic fever activities had graduated to a separate committee, it was felt that a new subject for study should be adopted.

The consensus of opinion of committee members was that hypertension in its various aspects would furnish its major project, and it was planned to assign to each member some particular facet for future development into a comprehensive discussion on that phase of the question. This series of reports might later be incorporated into a brochure for distribution to the profession, and possibly utilized as a fulcrum for a program of public education.

The chairman recommends that, since this a fairly long-time project, the personnel of the committee suffer no drastic changes over the next few years.

Respectfully submitted,

R. M. McKean, M.D., *Chairman*
C. B. Beeman, M.D.
D. R. Boyd, M.D.
J. R. Brink, M.D.
B. B. Bushong, M.D.
M. S. Chambers, M.D.
F. P. Currier, M.D.
R. A. Johnson, M.D.
F. D. Johnston, M.D.
Mark Marshall, M.D.
E. D. Spalding, M.D.
A. E. Vogelin, M.D.

ANNUAL REPORT OF ETHICS COMMITTEE—1946-47

Your Ethics Committee begs to report that it has had nothing to do during the past year.

This denotes a very healthy condition of affairs and is evidence of harmony within the profession.

Respectfully submitted,

G. B. Hoops, M.D., *Chairman*
A. J. Baker, M.D.
L. O. Geib, M.D.
L. C. Harvie, M.D.
M. M. Marrin, M.D. (deceased)
E. T. Morden, M.D.
D. R. Smith, M.D.
LeMoyne Snyder, M.D.

ANNUAL REPORT OF COMMITTEE ON NURSES' TRAINING SCHOOLS, 1946-47

A complete report is not available, as contacts are yet to be made with the Board of Registration of Nursing and the Michigan State Nursing Association. A supplemental report will be made from the floor at the meeting of the House of Delegates upon completion of these matters. We are arranging for a meeting of the officers of both nursing groups to meet with the Nursing Committee of the Michigan State Medical Society.

Respectfully submitted,

C. G. Clippert, M.D., *Chairman*
W. D. Barrett, M. D.
R. L. Haas, M.D.
E. A. Oakes, M.D.
W. J. Smith, M.D.
D. W. Thorup, M.D.

ANNUAL REPORT OF BEAUMONT MEMORIAL COMMITTEE—1946-47

In the report of last year, the Chairman recommended that the Committee be retired. However, there have been some new developments this year and if the Presi-

dent and The Council wish to have the Committee in being, it might still have a function.

The Early House was purchased through the generosity of Parke-Davis and Company and presented to the Mackinac Island State Park Commission. There has been a good deal of discussion concerning the proper use to which this house could be put. Professor Lorch, now Professor Emeritus of the School of Architecture of the University of Michigan, has been interested in this house from an historical viewpoint and he has been making a determined search to find out all the facts concerning the original construction and the subsequent additions made to this house.

As yet he has not been able to get the original plans of the house as it existed at the time of the wounding of Alexis St. Martin. The files of the American Fur Trading Company, The Astor estate and the Canadian Archives have been searched, and at the present time we are in communication with the central offices of the Hudson Bay Fur Trading Company in London. It is definitely established that this house has been rebuilt and added to on several occasions but the final story is not yet clear.

Because of this activity and in view of the fact that the Park Commission will, we are sure, be glad to have advice from the State Medical Society, we suggest to The Council and President that our Committee be continued or another one appointed so that consultation from the State Society can be available to the Park Commission and to the hostorians now studying the problem.

Respectfully submitted,

F. A. Coller, M.D., *Chairman*
A. W. McDonald, M.D., *Vice Chairman*
F. C. Kidner, M.D.
A. W. Lescohier, M.D.
H. C. Mayne, M.D.

ANNUAL REPORT OF COMMITTEE ON RHEUMATIC FEVER CONTROL—1946-47

The Committee on Rheumatic Fever Control held six meetings during the past year. The diagnostic groups in the various areas of the state examined 397 children referred to them and established the diagnosis of rheumatic fever in 150. These cases were drawn from about one-half the population of the state since several populous counties had not yet been activated. The number of centers is being increased by five since last year, and these centers are being established at Muskegon, Battle Creek, Saginaw, Pontiac, and Port Huron.

Financial support of the diagnostic centers has been adequate due to the magnificent gift of $15,000 from the Michigan Society for Crippled Children and Disabled Adults. This fund has been renewed for the coming year.

A national women's fraternity alumni association, Alpha Phi, has asked to co-operate with us in any possible way they may help in the work.

At a recent meeting of the committee with representatives from the fraternity, their organization was outlined, and the suggested methods, by which assistance can be given, were as follows:

(a) It was suggested that some centers, such as Traverse City, which covers a wide area, could use assistance in providing transportation to and from the center for patients to be examined.

(b) Some centers might be able to use secretarial and other assistance in preparing the patients for examination on examination day, possibly requiring three or four hours weekly for one or two persons.

(c) Qualified individuals would be welcomed to assist the public health nurses in follow-up of cases under the direction of the diagnostic group.

(d) There is a great need for summer camp convalescent facilities for children recovering from rheumatic fever. Competent medical guidance by physicians and nurses and play-ground supervisors should be provided.

(e) It was also suggested that some individuals who are classified as indigent find it difficult, or impossible, to finance the laboratory examination fees. Possibly the Alpha Phi Fraternity Alumni Groups might be able to provide facilities for the cost involved with reference to the diagnosis of rheumatic fever in this income group.

(f) Another important service the Fraternity might render is that of helping to spread accurate information concerning rheumatic fever with especial reference to its widespread prevalence, the need for early recognition and treatment and co-operation in the rheumatic fever program.

The educational activities of the lay groups can be greatly augmented.

This affiliation with the volunteer workers through the state will be a great assistance to the local diagnostic groups.

It is hoped that within the next year the entire state will be activated in a state-wide program, by which any physician may share the responsibility of diagnosing rheumatic fever and rheumatic heart disease with a diagnostic group in his locality.

We are continuing a policy of avoiding dramatization of the disease and, if possible, false or insecure diagnosis.

Respectfully submitted,

H. H. Riecker, M.D., *Chairman*
W. B. Bloemendal, M.D.
N. E. Clarke, M.D.
Carleton Dean, M.D.
Douglas Donald, M.D.
L. Fernald Foster, M.D.
L. Paul Ralph, M.D.
Frank VanSchoick, M.D.
J. L. Wilson, M.D.
Mr. P. C. Angove

ANNUAL REPORT OF PROFESSIONAL LIAISON COMMITTEE—1946-47

The Professional Liaison Committee had no meeting during 1946-47, as no matters or problems within the purview of this committee's activities were referred to it.

Respectfully submitted,

W. D. Mayer, M.D., *Chairman*
C. E. Lemmon, M.D.
H. B. Zemmer, M.D.

ANNUAL REPORT OF COMMITTEE ON INFECTIOUS DIARRHEA, 1946-47

During the past year two meetings of the entire committee were held in addition to several conferences between the chairman and representatives of the State Health Department. Reference was made to the work of the committee in an editorial appearing in the February issue of the MSMS Journal.

The frequent occurrence throughout the country of epidemics of diarrhea of the newborn calls attention to the seriousness of the situation. No hospital should consider itself immune merely because of a good past record. The great increase in the percentage of hospital deliveries calls for improved hospital facilities and technique if epidemics are to be prevented.

The presence of pediatricians, obstetricians and State Laboratory representatives on the committee provides proper balance. Some progress has been made but much remains to be done.

Respectfully submitted,

R. M. Kempton, M.D., *Chairman*
Campbell Harvey, M.D.
Harold Henderson, M.D.
W. F. Seeley, M.D.
G. D. Cummings, M.D.

ANNUAL REPORT OF SPECIAL COMMITTEE ON UNIFORM FEE SCHEDULE FOR GOVERNMENTAL AGENCIES—1946-47

This Committee was enlarged to ten members so as to permit it to handle more intelligently some of the problems of revision that have been presented.

The entire fee schedule was reviewed in light of the local conditions presented by the State of Michigan and the National problem particularly with reference to the Veterans Fee Schedule. Contacts were made with and discussions were held with various state agencies in an attempt to iron out specific difficulties that had occurred.

All the county societies were contacted with special reference to the mileage fee. Discussions with the Veterans Administration in Washington were held.

Reports of the committee were transmitted to The Council and it is expected that a revised fee schedule will be printed in the near future.

Respectfully submitted,

R. L. Novy, M.D., *Chairman*
Frank VanSchoick, M.D.
A. B. Smith, M.D.
E. R. Witwer, M.D.
C. E. Toshach, M.D.
Arch Walls, M.D.
E. C. Texter, M.D.
E. C. Baumgarten, M.D.
R. V. Walker, M.D.
W. E. Johnston, M.D.

ANNUAL REPORT OF COMMITTEE ON STATE VETERANS AFFAIRS—1946-47

As there was no business brought before this committee, no committee meetings were held.

Respectfully submitted,

L. E. Sevey, M.D., *Chairman*
G. C. Penberthy, M.D., *Vice Chairman*
W. W. Babcock, M.D.
C. W. Brainard, M.D.
O. A. Brines, M.D.
Wm. Bromme, M.D.
W. C. C. Cole, M.D.
W. W. Ellet, M.D.
H. B. Fenech, M.D.
James Fyvie, M.D.
J. V. Fopeano, M.D.
R. F. Hauge, M.D.
S. W. Hartwell, M.D.
J. E. Ludwick, M.D.
K. S. McIntyre, M.D.
H. C. Mitchell, M.D.
W. E. Nesbitt, M.D.
C. I. Owen, M.D.
F. H. Power, M.D.
C. W. Reutter, M.D.
Paul Schrier, M.D.
J. M. Sheldon, M.D.
R. W. Teed, M.D.
J. M. Wellman, M.D.
Stuart Yntema, M.D.

ANNUAL REPORT OF COMMITTEE ON MICHIGAN HIGH SCHOOL ATHLETIC ACCIDENT BENEFIT FUND—1946-47

The committee appointed to act as liaison between the Michigan State Medical Society and the Michigan High School Athletic Accident Benefit Fund under the Department of Education had two meetings during the year. The background of the formation of this plan and its present activities in detail have been presented to the members of the Society in the April issue of The Journal. This report was made at the request of the committee in order that there would be a better understanding between the Athletic Benefit Plan and the medical profession. The officers of the plan have under consideration the adoption of the uniform fee schedule of the State Medical Society, but final action has not been taken.

It is recommended that county medical societies be stimulated to hold meetings on the subject of the High School Athletic Benefit Plan and invite the coaches or athletic directors to present the subject at their meetings, especially in the larger communities. The committee feels that this action can be done on a local scale to a better advantage than recommending that uniform procedures be followed in a county.

The Ingham County Medical Society has already set up a plan for medical attention to high school athletes in conjunction with the Benefit Plan and it is the feeling of the Ingham County Society that such care is a community responsibility.

Respectfully submitted,

S. W. Donaldson, M.D., *Chairman*
L. Fernald Foster, M.D.
E. R. Witwer, M.D.

ANNUAL REPORT OF COMMITTEE ON NATIONAL EMERGENCY MEDICAL SERVICE—1946-47

The Committee on National Emergency Medical Service was appointed for the year 1946-47 with instruction to "stand by," awaiting submission of such matter as should properly come before it for consideration. Since no such matter has been presented to the committee or to its chairman, no meetings have been held.

Respectfully submitted,

H. F. Becker, M.D., *Chairman*
W. H. Gordon, M.D.
R. F. Hague, M.D.
J. A. Ramsey, M.D.
S. W. Hartwell, M.D.
W. G. Ellet, M.D.
W. H. Alexender, M.D.

ANNUAL REPORT OF SPECIAL COMMITTEE TO MEET WITH CONGRESSMAN ENGEL—1946-47

On February 14, 1947, Drs. L. Fernald Foster, C. E. Umphrey, and W. H. Huron, as representatives of the Michigan State Medical Society, attended a dinner in Washington given in honor of Michigan's Congressional delegation. Our delegation performed an outstanding public relations effort in their subsequent contacts with not only Congressman Engel, but with all of our Michigan legislators. An understanding of the difficulties and problems facing our law makers and knowledge regarding proper techniques in making contacts was obtained. This will prove of great benefit to the Michigan State Medical Society.

Respectfully submitted,

E. F. Sladek, M.D., *Chairman*
O. D. Stryker, M.D.
R. S. Morrish, M.D.
P. L. Ledwidge, M.D.
L. Fernald Foster, M.D.

ANNUAL REPORT OF INDUSTRIAL STUDY COMMITTEE—1946-47

No meetings of the Industrial Study Committee were held during the year.

The present chairman recommends that this committee be continued since there are a number of questions of importance which might well be studied and worked over at the appropriate time.

Respectfully submitted,

S. W. Insley, M.D., *Chairman*
T. K. Gruber, M.D.
H. B. Fenech, M.D.
L. W. Hull, M.D.

Technical Exhibits

Abbott Laboratories **Booth No. C-5**
North Chicago, Illinois

You are most heartily invited to visit the display prepared for this meeting. Abbott Professional Service Representatives will be glad to discuss with you the wide variety of pharmaceutical specialties on display.
So! Be sure to visit the Abbott booth.

A. S. Aloe Company **Booth No. A-10**
St. Louis, Missouri

The Michigan representatives of the A. S. Aloe Company will welcome their friends at Booth No. A-10 where they will have on display a representative cross section of our complete line of Surgical, Hospital, and Laboratory equipment and supplies. Featured will be a complete line of government surplus instruments available at the present time—especially selected, fully certified instruments at approximately one half the regular cost.

Ames Company, Inc. **Booth No. D-6**
Elkhart, Indiana

Clinitest is a tablet method for the detection of urine-sugar. It is a copper-reduction test which develops its own heat within the test tube.
Ames representatives will be glad to discuss the therapeutic indications of the Ames Bile Acid Products, Decholin, Degalol and Cholmodin, with attending physicians.

Armour & Company **Booth No. B-1**
Chicago, Illinois

The Armour Laboratories cordially invite members of the Michigan State Medical Society to visit the Armour display in Booth No. B-1. The Armour booklet on "The Thyroid Gland and Clinical Application of Medicinal Thyroid," may be obtained at the Armour booth by those members who have not already received their copies.

Ayerst, McKenna & Harrison, Ltd. **Booth No. E-10**
New York, New York

Ayerst products displayed at the Michigan State Medical Annual Session will be:
"Premarin"—an orally active potent preparation of naturally occurring, water-soluble, conjugated estrogens containing sodium estrone sulfate as one of its estrogens.
"Enziflur"—a fluorine-bearing preparation containing vitamins C and D, recommended as an aid in inhibiting dental caries.

Baker Laboratories **Booth No. B-4**
Cleveland, Ohio

The Baker display is built around the six-step approach to optimum infant nutrition which leads to the picture of the happy mother and the healthy child. An adjusted protein, two carbohydrates, a modified fat, vitamins, soluble mineral salts and iron, coupled with simplicity of preparation and low cost, provide for complete nutrition and insure co-operation in the home. Baker's Modified Milk, liquid or powder, may be used interchangeably from birth to the end of the bottle-feeding period. May we discuss your infant feeding problem with you?

Bard-Parker Company, Inc. **Booth No. C-18**
Danbury, Connecticut

Bard-Parker Rib-Back surgical blades; surgical knife handles; long knife handles for deep surgery; Bard-Parker Formaldehyde Germicide; sterilizing containers; transfer forceps; hematological cases for obtaining bedside blood samples; and a new product, Chlorophenyl, a disinfectant.

Barry Laboratories, Inc. **Booth No. D-5**
Detroit, Michigan

Representatives of the Barry Laboratories, Inc., will be on hand to discuss and determine the correct selection of allergens for any physician's individual practice. Custom-made or Rx. desensitization treatment materials which make it possible for the general practitioner and others in specialties to treat as the patient's individual condition directs, as indicated by skin test reactions and history will be demonstrated. The Biological Division will exhibit the latest sterile injectable solutions in ampules and multiple dose vials which are of current interest to the medical profession.

Becton, Dickinson & Company **Booth No. D-12**
Rutherford, New Jersey

In Booth No. D-12, Becton, Dickinson & Company will have on display a full line of hypodermic equipment, including some new outfits designed for use in administering continuous caudal and continuous spinal analgesia. The use of vacutainer equipment in a new method of taking blood samples will be demonstrated by their representatives, Mr. V. R. Littlefield and Mr. T. Starling. The exhibit will feature a full line of Ace Bandages, clinical thermometers, B-D Manometers and other diagnostic instruments.

The Borden Company **Booth No. B-18**
New York, New York

Protolac, a new especially formulated blend of intact proteins and high protein products derived from animal and vegetable sources is on exhibit at Booth No. B-18. Protolac is supplemented with choline and the amino acid cystine. Protolac is indicated in high protein therapy in conditions requiring increased dietary protein of optimum nutritional value.
Likewise exhibited will be our long established products for infant feeding: Biolac, Dryco, Mull-Soy, Merrell-Soule Special Milks, general purpose Klim, and Beta Lactose.

Brewer & Company, Inc. **Booth No. E-12**
Worcester, Massachusetts

This exhibit consists of specialties, centering around Thesodate, the original enteric-coated tablet of Theobromine Sodium Acetate, and Luasmin, a combination of Theophylline Sodium Acetate, Phenobarbital and Ephedrine for the treatment of asthma. Also, Brewer Capsules and Ampuls, other specialties and standard pharmaceuticals manufactured by Brewer & Company, Inc., including a complete line of Vitamin preparations for internal use and injection. Gel-ets, the newest mode in oral vitamin therapy, are also featured.

Brooks Appliance Company **Booth No. D-15**
Chicago, Illinois

The Brooks Appliance Company will display a complete line of Bandages, First Aid Dressings, proctological Instruments, Needles, Syringes and the newest In Elastic Hosiery.
Mr. W. C Ayer, Brooks representative, will have charge

and will describe in detail the technique of applying the new Combination Pressure Bandages, Contura plus Pressoplast, which are used in treating of phlebitis and varicose ulcers.

Burroughs Wellcome & Co. (U.S.A.) Inc. Booth No. C-2
New York, New York

Burroughs Wellcome & Co., New York, cordially invite physicians to their exhibit of a representative group of fine pharmaceuticals and chemicals. Of particular interest are Nutragest, the palatable dietary compound containing the amino acids, important minerals, vitamins and carbohydrates; Digoxin, a pure, stable, crystalline glycoside of Digitalis lanata, combining uniform potency with rapidity of action; Wellcome Benzyl Benboate Emulson, the 24-hour treatment for scabies and pediculosis capita; and LUBA-FAX brand Surgical Lubricant.

Camel Cigarettes **Booth No. A-11**
New York, New York

Camel Cigarettes will present a dramatic full color review of their recent medical research on smoking, as well as the details of the nationwide survey showing that "More Doctors Smoke Camels Than Any Other Cigarette." Another panel will illustrate the absorption of nicotine in the respiratory tract. Representatives will be present.

Cameron Heartometer Company **Booth No. C-22**
Chicago, Illinois

See the improved Heartometer, a scientific precision instrument for accurately recording systolic and diastolic blood pressures, also furnishing a permanent graphic record of the pulse rate, disturbances of the rhythm, myocardial response, the action of the valves, as well as peripheral vascular circulation. The Heartometer clearly reveals heart disturbances in both early and advanced stages, and is of great value in checking the progress of medication and treatments.

Cameron Surgical Specialty Company **Booth No. D-21**
Chicago, Illinois

See the new Cameron Electro-Surgical Units, Coagulair-Sigmoidoscope, Electro-Diagnostosets, Flexible Gastroscopes, Bronchoscopes — Esophagoscopes — Laryngoscopes, Mirrolite, Binocular Spectacle Loupe, Magniscope and other specialties.

Carnation Company **Booth No. A-3**
Oconomowoc, Wisconsin

You are invited to visit the Carnation Company Booth No. A-3, where you will see an attractive display presenting some interesting information on the various uses of Carnation Vitamin D Evaporated Milk for infant feeding, child feeding, and general diet purposes. The method by which Carnation Milk is generously fortified with Vitamin D—400 U.S.P. Units per reconstituted quart—will be explained. Valuable literature will also be available for distribution.

Ciba Pharmaceutical Products, Inc. **Booth No. E-7**
Summit, New Jersey

Ciba Pharmaceutical Products, Inc., Summit, New Jersey (Booth No. E-7) cordially invite you to visit their exhibit for latest information on Pyribenzamine, the new anti-histaminic compound; Privine, a long-acting nasal vasoconstrictor; Metandren, the potent androgen for sublingual absorption and many others. Representatives in attendance will be ready to answer your questions.

Coca-Cola Company **Booth No. A-16**
Atlanta, Georgia

Coca-Cola will be served through the joint courtesy of Coca-Cola Bottling Company of Grand Rapids and The Coca-Cola Company.

Davis & Geck, Inc. **Booth No. A-8**
Brooklyn, New York **plus Cinema Room**

Davis & Geck, Inc., will display a comprehensive line of sutures specially prepared to fulfill the needs of every surgical technique. Special sutures for intestinal, eye, skin, tension, thyroid, plastic and thoracic surgery are included.

The D&G Surgical Film Library will present pictures prepared in collaboration with eminent surgical authorities on subjects of interest to those attending the meeting.

Davis & Geck will be represented by Messrs. Fred A. Geck and Merle Elliott.

DePuy Manufacturing Company **Booth No. E-20**
Warsaw, Indiana

DePuy will exhibit in Booth E-20 fracture appliances such as the well known dependable Lorenzo Bone Set, the new DePuy Bone Drill and the Can't Drop Screw Driver Set, which holds the bone screws completely around the head. Many other items of interest will be on display. Our booth will be conducted and supervised by Mr. C. F. Klingel, who will be amply able to answer any of your questions. He is a veteran in the field and will handle all of your problems with courtesy and intelligence.

Detroit Creamery Company **Booth No. D-10**
Detroit, Michigan

Don't overlook the advantages of Sealtest Quality controls—and our own scientific Sealtest Laboratory supervision. They safeguard the purity and delicious flavor of Sealtest Milk and Ice Cream.

Detroit X-Ray Sales Company **Booth No. E-17**
Detroit, Michigan

The Detroit X-Ray Sales Company again features the latest designs in Shockproof X-Ray Equipment. They extend a cordial invitation to visit this exhibit. Of particular interest will be the showing of the latest developments in Photo-Fluorographic Units for hospital admission chest x-rays.

Doho Chemical Corporation **Booth No. C-7**
New York, New York

The makers of Auralgan are introducing at this meeting, their sulfa drug preparation O-Tos-Mo-San, indicated in the treatment and control of chronic suppurative ears.

The Doho representatives will be happy to explain, in detail, the workings of these medications. Also to distribute the latest series of three (3) Anatomico-Pathologic Charts of the Ear, in color, suitable for framing.

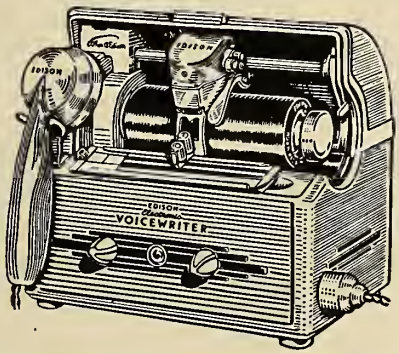
Eaton Laboratories, Inc. **Booth Nos. E-13, E-15**
Norwich, New York

Eaton Laboratories, Inc. will exhibit several pharmaceutical preparations of interest to the physician. Furacin Soluble Dressing containing a new chemo-

therapeutic agent, Furacin (brand of nitrofurazone), will be exhibited. This compound is a new antibacterial agent for the treatment of wound and surface infections. Clinical evaluation throughout the past two and one-half years indicates a wide field of use. Eaton representatives will be pleased to discuss Furacin Soluble Dressing with all physicians. Literature and samples will be available at the Eaton Laboratories, Inc. Exhibit.

The Ediphone Company **Booth No. D-13**
Grand Rapids, Michigan

The Ediphone Company extends a cordial invitation to visit the display of Ediphone Voicewriting Equipment. See the new Edison Electronic Voicewriter



identified by its Ear-Tuned Jewel-Action; also Miracle Models, manufactured by Edison who invented and perfected sound recording. Stop in for demonstration and to learn how we are helping the medical profession.

Ethicon Suture Laboratories **Booth No. C-16**
New Brunswick, New Jersey

Ethicon Suture Laboratories presents at Booth No. C-16 a complete line of sutures for every surgical procedure. Of greatest interest is Ethicon's New Bonded Catgut, Tru-Gauged and Tru-Chromicized with up to 30 per cent greater strength. Also exhibited are Ethicon's eyeless Atraloc Needles for minimal tissue trauma and Ethicon's Black Braided Silk on spools and in tubes.

H. G. Fischer & Company **Booth No. D-18**
Chicago, Illinois

Visitors to the 82nd Annual Session of the Michigan State Medical Society are cordially invited to visit the FISCHER Display Booth, to inspect the new units of FISCHER apparatus to be shown, along with the modern trends in shock-proof x-ray and electro-surgical-medical equipment construction. FISCHER units of apparatus are characterized by precision design and convenient, efficient operation. Members of the FISCHER organization will be present at all hours to answer questions and to demonstrate outstanding features of FISCHER equipment and performance. You will be welcome at the FISCHER Booth.

C. B. Fleet Company, Inc. **Booth No. C-20**
Lynchburg, Virginia

C. B. Fleet Co., Inc. cordially invites you to stop by Booth No. C-20 for a short visit with Mr. James A. Reed, the representative who sees you in your office about once a year. Perhaps there is something about Phospho-Soda (Fleet), the pure, stable, aqueous concentrate of the two U.S.P. Sodium Phosphates, you would like to discuss with him

General Electric X-Ray Corporation **Booth No. A-7**
Detroit, Michigan

Factual discussions with members of our Michigan sales and service organization during the state meeting will aid you in your future apparatus planning. If you are thinking about new and improved x-ray or electro-medical apparatus, our Layout Engineers can help you with detailed plans and specifications.
Possibly an improvement in radiographic end results is indicated. Or you may wish to know how G.E.'s Periodic Inspection and Adjustment Service can help keep your equipment at its maximum operating efficiency. Why not drop in and avail yourself of our wide experience and know-how?

Gerber Products Company **Booth No. B-10**
Fremont, Michigan

You are invited to visit Gerber's Baby Foods booth. A qualified nutritionist will be in attendance and will be glad to answer questions on Gerber's Baby Cereals, Gerber's Strained Foods and Gerber's Chopped Foods. Samples of Barley Cereal, Cereal Food, and Strained Oatmeal will be available.

Otis E. Glidden & Company, Inc. **Booth No. E-14**
Evanston, Illinois

ZymenoL, a palatable emulsion containing Brewers' Yeast (no live cells) provides effective bowel management, without irritant, habit-forming drugs, dehydrating purgatives, or agents producing artificial bulk. Teaspoonful dosage provides minimum liquid petrolatum intake, not likely to interfere with digestive processes or fat soluble vitamin absorption, and avoids leakage.
ZymenoL and descriptive literature gratis.

Hack Shoe Company **Booth No. E-8**
Detroit, Michigan

Correct shoes for men, women and children—including doctors and their families. The new Hack Convalescent Boot, adopted by the Medical Department of the U. S. Army will be on exhibit as well as Hack-O-Pedic Clubfoot and Surgical Shoes.

Hanovia Chemical & Mfg. Company **Booth No. C-4**
Newark, New Jersey

Black light for diagnostic purposes will be a feature of the exhibit. New self-lighting type ultraviolet lamps for body and orificial treatment will be part of the exhibit, as well as new Safe-T-Aire equipment for the destruction of air-borne bacteria. Courteous and competent representatives will be available to greet you.

J. F. Hartz Company **Booth No. B-20**
Detroit, Michigan

The J. F. Hartz Company again welcomes the opportunity to exhibit at the MSMS Convention.
Hartz representatives Messrs. Anderson, Ferrara, Grand, Kirpluk, MacKinnon, Sawall, and VanHaaften will be on hand to answer any questions relative to Hartz Laboratory Controlled Pharmaceuticals and full line of equipment and instruments.

H. J. Heinz Company **Booth No. D-22**
Pittsburgh, Pennsylvania

H. J. Heinz Company is displaying Heinz Strained and Senior Foods for infant feeding. Their representatives would appreciate your recommendations regarding these products.

Hoffmann-La Roche, Inc. **Booth No. C-10**
Nutley, New Jersey

Roche, the makers of "Medicines of Rare Quality" and vitamins by the ton, will exhibit various prescription specialties, among them Prostigmin, the versatile parasympathetic stimulant; Per-Os-Cillin, the new oral penicillin tablet; Ephynal Acetate, the Roche brand of pure vitamin synthetic vitamin E, and other products of interest to members of the profession.

A staff of representatives will be present to greet and render whatever service possible to visitors at the Roche booth.

Holland-Rantos Company, Inc. **Booth No. E-2**
New York, New York

You are cordially invited to visit the Holland-Rantos Booth where on display will be the nationally known and universally used Koromex contraceptive specialties. Besides the new Koromex Set Complete, which is a package combining the necessary items for complete contraceptive technique, will be the new Nylmerate Jelly, introduced only a short time ago and received enthusiastically for the treatment of trichomoniasis and vaginal discharges of a non-specific origin.

Representatives of the company will be on hand to answer all questions. Samples of Nylmerate Jelly and Koromex Jelly will be available, as will copies of the new physician's patient instruction chart.

G. A. Ingram Company **Booth Nos. C-13, C-15, C-17**
Detroit, Michigan

The G. A. Ingram Company of Detroit will exhibit a complete line of surgical instruments in both stainless steel and chrome, as well as all available electrical appliances. Their representatives will be more than pleased to have you call and obtain information on both new and old items.

"The 'Junket' Folks" **Booth No. D-17**
Little Falls, New York

In Booth No. D-17, "The 'Junket' Folks," Chr. Hansen's Laboratory, Inc., enlarged photos illustrate the action of the rennet enzyme in forming softer, finer milk curds. Free literature describes dietary uses of rennet-custards in infant, child, convalescent, or post-operative feeding. Attendants on duty. Complimentary package of "Junket" Rennet Powder and "Junket" Rennet Tablets will be presented to physicians who register.

H. W. Kinney & Sons, Inc. **Booth No. E-1**
Columbus, Indiana

H. W. Kinney and Sons, Inc. will exhibit Cartose and the Kinney line of nutritional products at Booth No. E-1. Company representatives will be in attendance and will be happy to be of service to any physicians who care to visit at the exhibit.

A. Kuhlman & Company **Booth Nos. A-14, A-15**
Detroit, Michigan

The A. Kuhlman & Co. most cordially invites you to visit the display at Booth Nos. A-14 and A-15.

You will find on display Stille Surgical Instruments, Hamilton Medical Furniture, A.C.M.I. Cystoscopes, Short Wave Diathermy (short wave diathermy meets requirements of Federal Communication Commission), and many other items of interest to the Physician and Surgeon.

Lea & Febiger **Booth No. B-16**
Philadelphia, Pennsylvania

At Booth No. B-16, Lea & Febiger will exhibit among their new works and new editions Gifford's Ocular Therapeutics, Schwartz, Tulipan & Peck's Occupational Diseases of the Skin, Lewin's Foot and Ankle, Goldberger's Unipolar Lead Electrocardiography, Frohman's Brief Psychotherapy, Joslin's Treatment of Diabetes, Stimson's Common Contagious Diseases, Bell's Pathology, Quiring's The Extremities and The Head, Neck and Trunk, Cushny's Pharmacology and Therapeutics, Wintrobe's Hematology and other standard works.

Lederle Laboratories **Booth No. D-16**
New York, New York

Lederle Laboratories will have on display the new Folic Acid products about which there has been so much interest. Among the products to be shown will be Folvite—Lederle's brand of Folic Acid, and Folvron—Folic Acid and Iron, by which both iron-deficiency anemias and macrocytic anemies may be treated.

Libby, McNeill & Libby **Booth No. D-7**
Chicago, Illinois

Libby's Vitamin D³ Fortified Homogenized Evaporated Milk and Libby's Strained and Homogenized Baby Foods are featured at the Libby Booth. Physicians are invited to stop and discuss new findings on the greater availability of iron and ease of digestion of Libby's Council-accepted foods for babies.

Liebel-Flarsheim Company **Booth No. C-8**
Cincinnati, Ohio

The Liebel-Flarsheim Company cordially invites you to stop at Booth No. C-8 for examination and demonstration of the Model SW-227 Frequency-Controlled Shortwave Diathermy Unit, as well as our Bovie electrosurgical apparatus. Capable representatives will be on hand at all times to answer your questions about our physical-therapy and electrosurgical equipment.

Eli Lilly & Company **Booth No. B-8**
Indianapolis, Indiana

The Lilly exhibit this year features an interesting presentation on the heart and a discussion on cardiac drugs. Many Lilly products are to be on display; representative literature will be available. The attending Lilly medical service representatives will be pleased to assist visiting physicians whenever possible.

J. B. Lippincott Company **Booth A-13**
Philadelphia, Pennsylvania

J. B. Lippincott Company, Philadelphia, Pa., presents a complete line of Lippincott Selected Professional Books and Journals.

Be sure to see the current issue of American Practitioner—the monthly medical journal designed to shorten the lag between experiment and practice.

Titles of new books and new editions include: Dermatology and Syphilology, Signs and Symptoms—Their Clinical Interpretation, Diagnosis in Daily Practice, Diabetic Care in Pictures, Cardiovascular Diseases, Color Atlas of Hematology, Essentials of Endocrinology, Diseases of the Nose and Throat, Uterine Contractility in Pregnancy.

Medical Gas Division of Liquid Carbonic Corporation **Booth No. D-9**
Chicago, Illinois

The Liquid Carbonic Corporation will exhibit its complete line of Anesthesia, Therapeutic and Resuscitating Gases, as well as Oxygen Therapy equipment in Booth No. D-9.

M & R Dietetic Laboratories, Inc. **Booth No. E-3**
Columbus, Ohio

M & R Dietetic Laboratories, Inc., Booth No. E-3, will display Similac, a food for infants deprived either partially or entirely of breast milk. Messrs. R. E. Davis, F. H. Behncke, and L. A. MacDonald will appreciate the opportunity to discuss the merit and suggested application for both the normal and special feeding cases.

McKesson Appliance Company **Booth No. D-14**
Toledo, Ohio

Mead Johnson & Company **Booth Nos. A-4, A-5**
Evansville, Indiana

Servamus Fidem means "We are keeping the faith." Almost every physician thinks of Mead Johnson & Company as the maker of Dextri-Maltose, Pablum, Oleum Percomorphum, and other infant diet materials —including the new pre-cooked oatmeal cereal, Pabena. But not all physicians are aware of the many helpful services this progressive Company offers physicians. A visit to Booth Nos. A-4 and A-5 will be time well spent.

Medical Arts Surgical Supply Company **Booth Nos. C-1, C-3**
Grand Rapids, Michigan

The Medical Arts Surgical Supply of Grand Rapids again will occupy Booth Nos. C-1 and C-3. Their six salesmen from all parts of Michigan will be there to greet you and to show you medical furniture, short waves, x-ray, diagnostic equipment, surgical instruments and pharmaceuticals.

The exhibit will feature equipment of the latest type that will aid you in your daily practice.

Medical Case History Bureau **Booth No. C-19**
New York, New York

Simplifying the doctor's history record and bookkeeping system with the Info-Dex Record Control System. Maintenance of accurate, informative data on both history and financial records is essential in the modern doctor's practice. The Info-Dex Record Control System helps to keep a constant finger on the physical and financial pulse of the patient. This system correlates information almost automatically for instant reference and research work. Its method of cross-indexing interesting cases according to the disease is unique and exclusive. The Medical Case History Bureau has specialized for many years in record forms for the doctor's office. Their well-informed representative will gladly demonstrate the Info-Dex System and discuss your office problems.

Medical Film Guild **Booth No. A-6 plus**
New York, New York **Cinema Room**

Medical Film Guild through "Medical Films That Teach" presents a refresher course in fundamental medical problems. The films review such subjects as Parkinson's disease, major neuralgias, cervicitis, otolaryngological diseases, contagious diseases, arterial blood pressure, hypothyroidism, industrial medicine. These are available to medical institutions, including projection service at no charge, through grants for postgraduate instruction.

Medical Protective Company **Booth No. B-2**
Fort Wayne, Indiana

The most exacting requirements of adequate liability protection are those of the professional liability field. The Medical Protective Company, Specialists in providing protection for professional men, invites you to confer, at their exhibit, with the representatives there. They are thoroughly trained in professional liability underwriting.

Merck & Company, Inc. **Booth No. D-11**
Rahway, New Jersey

Since the discovery of Penicillin important strides have been made in the virtually unlimited field of antibiotic chemistry. With increased knowledge concerning Penicillin, it is known that there are at least four individual forms, namely Penicillin G, F, K, and X. It is the G form that is of most importance in medicine today, and it is this form, in high purity and without the presence of the F, K, and X entities, that is supplied as Crystalline Penicillin G Sodium Merck.

Streptomycin, now also well known by the medical profession for its established value in the treatment of certain diseases, as well as its potential value in others, is the result of a research program brilliantly conceived and methodically carried through to a successful conclusion. Merck production of Streptomycin has been steadily increased so that adequate supplies are available for medical needs.

Antibiotics have been chosen by Merck for their MSMS display. Chemical, pharmacological, and medical information is given.

Other fields, medical and nutritional, in which The Merck Research Laboratories are vitally interested, include the Amino Acids, the Vitamins, the Sulfonamides, Choline derivatives, and Anesthetic Agents.

Wm. S. Merrell Company **Booth No. A-2**
Cincinnati, Ohio

The Wm. S. Merrell Company, Cincinnati (Booth No. A-2) will feature the new Amino-Concemin. This more complete nutrient tonic designed to speed convalescence, contains the established B vitamins, the whole B complex from liver, rice bran and yeast, iron and 15 per cent protein hydrolysate. Its rich winey flavor represents an unusual taste accomplishment in a preparation containing liver, iron and amino acids.

Michigan Medical Service **Booth No. B-5**
Detroit, Michigan

Largest voluntary prepayment medical-surgical plan in the United States. Charts of progress for past year and from inception to date: (a) Assets and Liabilities; (b) Percentage income paid for administrative costs; (c) Paid Doctors for services rendered; (d) Number services rendered; (e) Incidence of service per year for 1,000 subscribers; (f) Cost per case and cases per 1,000 subscribers; (g) Growth in subscribers and services rendered; (h) Number of cases—Veterans program.

C. V. Mosby Company **Booth No. B-6**
St. Louis, Missouri

Physicians attending the Michigan State Medical Society Convention are cordially invited to visit Booth

No. B-6, where a wealth of new medical literature will be displayed by the C. V. Mosby Company.

New books to be shown will include Ackerman-Regato "Cancer," Treiger "Atlas of Cardiovascular Diseases," Clendening-Hashinger "Methods of Diagnosis," Eve "Handbook on Fractures," Wiener "Skin Manifestations of Internal Disorders," Scobee "The Oculorotary Muscles," and Johnstone "Occupational Medicine and Industrial Hygiene." New editions on display will include Top "Communicable Diseases," Crossen "Operative Gynecology," Watson "Hernia," Jeans-Marriott "Infant Nutrition," McCormick "Pathology of Labor, the Puerperium, and the Newborn," and Selling "Synopsis of Neuropsychiatry."

National Dairy Council — **Booth No. E-6**
Chicago, Illinois

You are cordially invited to visit the National Dairy Council exhibit of health education materials at Booth No. E-6.

Booklets and posters giving timely and authentic nutrition information will be on display. This literature may be used for distribution to patients or for the reception room. Sample material may be requested.

National Drug Company — **Booth No. E-4**
Philadelphia, Pennsylvania

You are cordially invited to visit our exhibit. Of specific interest will be the newest developments of our Research Laboratories; namely, our Amino Acid products—Aminonat, Aminovite and Protinal.

Also on display will be our time-tested, Council-Accepted biologicals, including the series of multiple antigens for simultaneous immunization.

Wm. R. Niedelson — **Booth No. C-5**
Detroit, Michigan

Still the leader of the basal metabolism testers, the Jones "Motor-Basal" will be shown, as will the first successful direct-recording electrocardiograph, the "Cardiotron." Showing for the first time, the new "Profex" Examining Table Model X-Ray for the general practitioner will be on display. This is an ideal unit for the limited space problem.

Ortho Pharmaceutical Corporation — **Booth No. D-19**
Raritan, New Jersey

Ortho Pharmaceutical Corporation cordially invite you to visit their booth, No. D-19. Their complete line of Gynecic Pharmaceuticals will be on exhibit, including Triple Sulfa Vaginal Cream for Bacterial Vaginitis and Nidoxital for nausea and vomiting of pregnancy. Samples and literature will be available on request.

Parke, Davis & Company — **Booth Nos. B-7, B-9, B-11, B-13**
Detroit, Michigan

The 1947 Parke, Davis & Co. Exhibit will highlight the Technical Aspects of Benadryl. Demonstrations of the fundamental uses of Radioactive Isotopes in Medical Research and their applicability to the study of the pharmacodynamic action of Benadryl will be depicted. Laboratory animals will be utilized in these daily demonstrations. You are cordially invited to visit this outstanding exhibit.

Pet Milk Company — **Booth Nos. B-12, B-14**
St. Louis, Missouri

A complete display of material illustrating the time-saving Pet Milk services available to physicians. Specially trained representatives will be in attendance to give you information about the production of Pet Milk and its use for infant feeding. Miniature cans will be given to physicians visiting the exhibit.

Philip Morris & Company, Ltd., Inc. — **Booth No. E-21**
New York, New York

Philip Morris & Company will demonstrate the method by which it was found that Philip Morris Cigarettes, in which diethylene glycol is used as the hygroscopic agent, are less irritating than other cigarettes. Their representative will be happy to discuss researches on this subject, and problems on the physiological effects of smoking.

Picker X-Ray Corporation — **Booth Nos. D-2, D-4**
Detroit, Flint, Grand Rapids, Michigan

Picker will exhibit the very popular "Century" diagnostic unit with some postwar improvements; also a complete line of radiographic and fluoroscopic accessories.

Pitman-Moore Company — **Booth No. A-9**
Indianapolis, Indiana

At Booth No. A-9, the Pitman-Moore display will feature a number of important Council-Accepted biological and pharmaceutical products. Medical service representatives from this area will be on hand to greet their friends in the medical profession, and members of the Pitman-Moore scientific staff will be in attendance to answer technical questions and explain recent scientific advances.

Procter & Gamble Company — **Booth No. E-18**
Cincinnati, Ohio

In Booth No. E-18, the Procter & Gamble Company offers the first four of a series of time-saving leaflet pads for doctors. These are entitled "Instructions for Routine Care of Acne," "Instructions for Bathing a Patient in Bed," "Instructions for Bathing Your Baby" and "The Hygiene of Pregnancy." Additional leaflet pads are being prepared, designed to save doctors time in answering patients' questions on routine home care. Also displayed will be other samples of service material prepared for the medical profession. Mrs. Christyne Schwab will be in charge of the booth.

Professional Management — **Booth No. E-22**
Battle Creek, Michigan

Professional Management—"A Michigan Institution with a National Reputation" will be on hand, as usual, with members of the firm available, not only to its hundreds of clients, but to all members of the MSMS for consultation regarding Office Records—Partnership Arrangements—Taxes—Fees and The Business Side of Medical Practice in general.

Radium Emanation Corporation **Booth No. E-11**
New York, New York

The Radium Emanation Corporation invites you to Booth No. E-11 where we will exhibit a wide variety of instruments and applicators used in modern radium therapy, including permanent and removable **Leak-Proof** radon seeds. Our representative will be available to explain this equipment and its usage.

Randolph Surgical Supply Company **Booth Nos. B-15, B-17**
Detroit, Michigan

Randolph Surgical Supply Company will display the latest developments in new equipment and other items of interest. On hand to greet Randolph's many friends will be Art Rankin, Fred Greenhut and Cliff Randolph.

W. B. Saunders Company **Booth No. D-20**
Philadelphia, Pennsylvania

W. B. Saunders Company, represented by Mr. Frank Patterson, will exhibit the complete line of their books including Hyman's "Integrated Practice of Medicine," Bockus' "Gastro-enterology," Lyons & Woodhall's "Atlas of Peripheral Nerve Injuries," Rubin's "Diseases of the Chest," Cooke's "Allergy," new editions of Wechsler's "Clinical Neurology," Ranson & Clark's "Anatomy of the Nervous System," Novak's "Gynecological and Obstetrical Pathology," Cecil's "Medicine," DeLee & Greenhill's "Obstetrics," Wharton's "Gynecology and Female Urology," Boyd's "Surgical Pathology," Duncan's "Diseases of Metabolism," McCombs' "Internal Medicine," and many others.

Schering Corporation **Booth No. A-1**
Bloomfield, New Jersey

The Schering booth will feature the potent oral estrogenic hormone, **Estinyl** (ethinyl estradiol), the oral progestin, **Pranono** (anhydrohydroxyprogesterone) and the oral androgen, **Oreton-M** (methyltestosterone). The well-known parenteral hormones, **Oreton** (testosterone propionate), **Progynon-B** (estradiol benzoate). **Proluton** (progesterone), and **Cortata** (desoxycorticosterone acetate) will also be displayed. The new effective treatment for ophthalmic infections, **Sodium Sulfacetimide Solution 30 per cent** will be of interest as will be the clinically safer sulfonamide combination **Combisul-TD** and the radiographic media **Priodax** and **Neo-Jopax**. Schering Professional Service Representatives will be present to welcome physicians' inquiries.

G. D. Searle & Company **Booth No. D-1**
Chicago, Illinois

Will show a number of products of Searle Research which have contributed so much to the armamentarium of the physician, including Searle Aminophyllin, Metamucil, Ketochol, Floraquin, Diodoquin, Pavatrine, Pavatrine with Phenobarbital, Gonadophysin, and Tetrathione.

Featured will be the new Aminophyllin Supposicones, the Searle brand of Aminophyllin Suppositories, which remain stable at temperatures up to 130° F, but which liquefy readily under conditions of use.

Sharp & Dohme, Inc. **Booth No. A-12**
Philadelphia, Pennsylvania

Sharp & Dohme extends a cordial welcome to all visitors at Booth No. A-12. New antibiotic preparations including "Prothricin" nasal decongestant and "Tyroderm," tyrothricin cream are being featured along with "Sulfathalidine" and "Sulfasuxidine," intestinal bacteriostatic agents. "Cremosuxidine," "Lyocyte" Powder, dried human blood cells and "Lyovac" Normal Human Plasma complete the items on exhibit.

Smith, Kline & French Laboratories **Booth No. E-5**
Philadelphia, Pennsylvania

Eskay's Oralator is featured at this exhibit.

Eskay's Oralator provides a revolutionary method of cough control. Inhaled by mouth, the Oralator's anesthetic-analgesic vapor (2-amino-6-methylheptane) is delivered directly to the nerve endings in the trachea and larynx, where it controls cough within a matter of seconds. Safe and effective, the Oralator is indicated in those types of coughs for which codeine would ordinarily be prescribed. Unlike sedatives and narcotics, however, the Oralator produces no appreciable systemic effects.

Our specially trained professional representatives will be glad to answer questions concerning the possible uses of our products in your practice.

Spencer Incorporated **Booth No. C-9**
New Haven, Connecticut

Spencer, Incorporated Exhibit—Featuring individually designed supports for abdomen, back and breast. Doctors will be especially interested in these supports for patients who have undergone mastectomy. They will also be interested in the Spencer Spinal Support for patients following cast removal, or as an aid to treatment of protruding disc and other back derangements. Supports for patients with hernia, visceroptosis with symptoms, postoperative needs, obesity, antepartum and postpartum needs are also on display.

E. R. Squibb & Sons **Booth No. D-8**
New York, New York

Nutrition in the Sick Patient: A scientific exhibit which presents new data on excretion and depletion of nutrients in the hospitalized patients on standard hospital diets; resulting changes in body chemistry; and measures suitable for the prevention of nutritional damage.

Frederick Stearns & Company Division **Booth No. D-3**
Detroit, Michigan

You are cordially invited to visit the exhibit of Frederick Stearns & Company Division.

Members of our professional staff will be in attendance to discuss such products as Parenamine, Demerol, various Neo-Synephrine products, Fergon, Adnephrin, and the complete list of Stearns ethical specialties.

Please register for any samples you may wish sent you.

VanPelt & Brown, Inc. **Booth No. E-16**
Richmond, Virginia

VanPelt & Brown, Inc., will exhibit a number of our prescription specialties. Of special interest are our products: Elixir and Tablets of Gluco Ferrum with Vitamin B_1 (Hematinic), Barbidonna (Sedative and Anti-Spasmodic), Theobarb (Vasodilator), and Elixir Mandechlor (Urinary Antiseptic). The exhibit will be conducted by Messrs. George J. Hulcher and T. Frank Brown. You are most cordially invited to visit our booth.

Westinghouse Electric Corporation **Booth Nos. C-12, C-14**
Pittsburgh, Pennsylvania

White Laboratories, Inc. **Booth No. B-3**
Newark, New Jersey

White Laboratories, Inc. at Booth No. B-3 present information regarding White's Sulfathiazole Gum—expressly formulated for topical chemotherapy in oropharyngeal infections; White's Otomide—a more effective means of topical chemotherapy in ear infections—and a NEW specialty, White's Mol-Iron Tablets, a new and definite advance in the treatment of iron deficiency anemias.

White's ethically promoted vitamin specialties are also featured. You will find a very cordial welcome by White's Medical Service Representatives in charge of the exhibit.

Winthrop Chemical Company, Inc. **Booth No. C-11**
New York, New York

Winthrop Chemical Company, Inc., New York (Booth No. C-11) extends a cordial invitation to visit its booth where representatives will be on hand to discuss the latest therapeutic contributions made by this firm. Featured will be Demerol, powerful analgesic, spasmolytic and sedative; Digisidin, crystalline digitoxin, the drug of choice for precise digitalization, and Crystalline Penicillin G in Oil and Wax, "Punctule" for simple, convenient administration of the Romansky formula.

Zimmer Manufacturing Company **Booth No. E-9**
Warsaw, Indiana

Mr. C. A. Fisher, factory representative, will exhibit a complete line of fracture equipment, including the popular Luck Bone Saw. New items on display for your approval will be, the Moreira Stud-Bolt for hip fractures, Doctor Eggers Contact Splint (slotted bone plate), complete set of New Bone Clamps, Intramedullary fixation Instruments, Adjustable Intertrochanteric Plate and Nail, Threaded Wires and Pins, Moore-Blount Plates and Instruments, New Rubber Cushion Walking Heel, and the Conn Tourniquet.

MEETINGS OF SPECIAL SOCIETIES AND ALUMNI GROUPS

1. Michigan Society of Anesthetists, Thursday, September 25, Room 322, Pantlind Hotel, 7:00 p.m., dinner. Election of officers and business meeting.
2. Detroit Urological Society, Tuesday, September 23, Room 222, Pantlind Hotel, 7:00 p.m., dinner. Speaker: George H. Ewell, M.D., Madison, Wisconsin—"The Surgical Complications of the Polycystic Kidneys."
3. Michigan Pathological Society, Friday, September 26, Room 222, Pantlind Hotel, beginning at 12:00 Noon and continuing through Friday afternoon and evening and also Saturday morning, September 27. Alan Moritz, M.D., Boston, Mass., and Mr. F. Roland Allaben, LL.B., Grand Rapids, will be the principal guest speakers.
4. Alumni of Northwestern University School of Medicine will meet Wednesday, September 24 at the Peninsular Club, Grand Rapids, 12:30 p.m. The luncheon is being arranged by Cochairman L. S. Griffith, M.D., P.W. Willits, M.D., J. H. Beaton, M.D., H. J. Damstra, M.D., and E. W. Schnoor, M.D., all of Grand Rapids.
5. Alumni Association of Loyola University School of Medicine will meet Tuesday, September 23, Room 322, Pantlind Hotel, 7:00 p.m., dinner.
6. The Medical Assistants Conference—Wednesday, September 24, Schubert Room, Pantlind Hotel, 4:00 p.m., followed by dinner at 6:30 p.m.
   Secretaries of all MSMS members are cordially invited to attend this informative Conference. No fee.
7. Wayne University Alumni Association "open house" from Tuesday noon to Friday noon, September 23-26—Parlor D., Mezzanine floor, Pantlind Hotel.

Have You Made Your

HOTEL RESERVATIONS?

MICHIGAN STATE MEDICAL SOCIETY

82nd Annual Session

Grand Rapids, September 23-24-25-26, 1947

The reservation blank below is for your convenience in making your hotel reservations in Grand Rapids. Please send your application to J. W. Logie, M.D., Chairman of Housing Committee, c/o Pantlind Hotel, Grand Rapids, Michigan. Mailing your application now will be of material assistance in securing hotel accommodations.

As very few singles are available, registrants are requested to co-operate with the Housing Committee by sharing a room with another registrant.

J. W. Logie, M.D., Chairman, Housing Committee,
Michigan State Medical Society Annual Session,
c/o Pantlind Hotel, Grand Rapids, Michigan.
Please make hotel reservation(s) as indicated below:

.....Single Room(s)

.....Double Room(s) for .....persons

.....Twin Bedded Room(s) for ....persons

Arriving September .....hour.....A.M.....P.M.

Leaving September .....hour.....A.M.....P.M.

(Names and addresses of all applicants including person making reservation).

Name	Address	City	State
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.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

Date ..... Signature .....

Address ..... City.....

Michigan State Medical Society
Roster 1947

(Special Memberships are indicated as follows: "E" for Emeritus Members; "L" for Life Members; "R" Retired Members, and "A" for Associate Members; all others are Active Members)

Allegan County

Baker, A. G. ... Allegan
Brown, Lewis Freeman ... Otsego
Brunson, Eugene T. ... Ganges
Burdick, J. G. ... Allegan
Corkill, C. C. ... Douglas
Dickinson, C. A. ... Wayland
Flinn, C. C. ... Allegan
Hudnutt, Orrin Dean ... Plainwell
Johnson, E. B. ... Allegan
Johnson, H. H. ... Martin
Kromer, R. A. ... Wayland
Mahan, James E. ... Allegan
Medill, W. C. ... Plainwell
Miller, K. C. ... Saugatuck
Ramseyer, Gladwin E. ... Plainwell
Rigterink, George H. ... Hamilton
Rummell, Robert J. ... Fennville
Stuch, Howard T. ... Allegan
Stuck, Olin H. ... Otsego
Ten Pas, Henry W. ... Hamilton
Van Ness, J. H. ... Allegan
Van Der Kolk, Bert ... Hopkins
Vaughan, W. R. ... Plainwell

Alpena-Alcona-Presque Isle Counties

Arscott, E. F. ... Rogers City
Bunting, John W. ... Alpena
Burkholder, H. J. ... Alpena
Constantine, Aeneas ... Harrisville
Foley, Arthur L. ... Rogers City
Hier, Edward A. ... Alpena
Jackson, W. F. ... Rogers City
Kessler, Harold ... Alpena
Lister, George F. ... Hillman
Nesbitt, Wm. E. ... Alpena
O'Donnell, F. J. ... Alpena
Parmenter, E. S. ... Rogers City
Pennington, James H. ... Alpena
Ramsey, J. A. ... Alpena
Wienczewski, Theophile ... Alpena

Barry County

Clarke, Daniel M. ... Hastings
Finnie, R. G. ... Hastings
Gwinn, A. B. ... Hastings
Harkness, Robert B. ... (L) Hastings
Keller, Guy C. ... Hastings
Lathrop, Clarence P. ... (E) Hastings
Lund, Chester A. E. ... Middleville
McIntyre, K. S. ... Hastings
Morris, Edgar T. ... (L) Nashville
Phelps, Everett L. ... Hastings

Bay-Arenac-Iosco Counties

Alcorn, Kent ... Bay City
Alcorn, Marshall ... Bay City
Allen, A. D. ... Bay City
Andrews, F. T. ... Bay City
Asline, J. N. ... Essexville
Austin, Justis ... Tawas City
Ballard, W. R. ... (E) Bay City
Boulton, A. O. ... (E) Gladwin
Brown, G. M. ... Bay City
Chapin, Frederick J. ... Bay City
Connelly, C. J. ... Bay City
Criswell, R. H. ... Bay City
Dardas, M. J. ... Bay City
DeWaele, Paul L. ... Bay City
Dolbee, Malcolm ... Standish
Drummond, Fred ... Kawkawlin
Dumond, V. H. ... Bay City
Fisher, Robert E. ... Bay City
Foster, L. Fernald ... Bay City
Freel, John A. ... Bay City
Gamble, W. G., Jr. ... Bay City
Groomes, Charles ... Bay City
Grosjean, J. C. ... Bay City
Gunn, Robert ... Bay City
Hagelshaw, G. L. ... Bay City
Hasty, Earl ... Whittemore
Hess, C. L. ... Bay City
Heuser, Harold H. ... Bay City
Horowitz, S. Franklin ... Bay City
Huckins, E. S. ... Bay City
Hughes, E. C. ... Bay City
Husted, F. Pitkin ... Bay City
Jacoby, A. H. ... Bay City
Jens, Otto ... Essexville
Johnson, Orlen J. ... Bay City
Jones, Jerry M. ... Bay City
Keho, John ... Bay City
Kerr, William ... (E) Bay City
Kessler, Mana ... Bay City
Kessler, Saba ... Bay City
Knobloch, Howard ... Bay City
Lerner, David ... Au Gres
Loftin, Robert ... Bay City
MacRae, L. D. ... Bay City
McDonnell, Walter R. ... Pinconning
McEwan, J. H. ... Bay City
MacPhail, Joseph ... Bay City
Medvezky, M. J. ... Bay City
Miller, Edwin C. ... Bay City
Miller, M. C. ... Bay City
Mitton, Orland W. ... East Tawas
Moore, George W. ... Bay City
Moore, Neal R. ... Bay City
Mosier, D. J. ... Bay City
Pearson, Stanley M. ... Bay City
Perkins, Roy C. ... Bay City
Reuter, C. W. ... Bay City
Savory, John ... Bay City
Scrafford, Royston Earl ... Bay City
Shafer, Harold C. ... Bay City
Sherman, R. N. ... Bay City
Smith, J. Campbell ... Bay City
Staley, Hugh ... Omer
Stinson, W. S. ... Bay City
Stuart, Alexander A. ... Bay City
Tarter, Clyde S. ... Bay City
Timreck, Harold A. ... Gladwin
Tupper, Virgil L. ... (R) Bay City
Urmston, Paul R. ... Bay City
Vail, Harry F. ... Bay City
Von Haitinger, Kalmon S. ... Auburn
Warren, E. C. ... (E) Bay City
Wilcox, J. W. ... Bay City
Wilson, Thomas G. ... Bay City
Wittwer, E. A. ... Bay City
Zaremba, Aloysius J. ... Bay City
Ziliak, A. L. ... Bay City

Berrien County

Anderson, H. B. ... Watervliet
Allen, Robert C. ... St. Joseph
Anderson, Bertha ... St. Joseph
Belsley, Frank K. ... Benton Harbor
Bjork, Harold ... St. Joseph
Bliesmer, A. F. ... St. Joseph
Brown, F. W. ... Watervliet
Burrell, H. J. ... Benton Harbor
Cawthorne, H. J. ... Benton Harbor
Conybeare, R. C. ... Benton Harbor
Crowell, Richard ... St. Joseph
Dunnington, R. N. ... Benton Harbor
Eidson, Hazel ... Berrien Springs
Emery, Clayton ... St. Joseph
Faber, Michael ... Benton Harbor
Fattic, G. R., Jr. ... Niles
Friedman, Morris ... New Buffalo
Garrett, Evan L. ... Niles
Gillette, Clarence H. ... Niles
Green, Robert ... Eau Claire
Gregory, James ... Berrien Center
Hanna, P. G. ... St. Joseph
Harper, Ina ... Benton Harbor
Harrison, L. L. ... Niles
Hart, Russell ... Niles
Helkie, W. L. ... Niles
Henderson, Fred ... Niles
Hershey, Noel J. ... Niles
Huff, H. D. ... Niles
King, B. B. ... Benton Harbor
King, Frank, Jr. ... Benton Harbor
Kling, H. C. ... Niles
Kok, Harry ... Benton Harbor
Lawton, Clare V. ... Benton Harbor
Leva, John B. ... Benton Harbor
Miller, E. A. ... Berrien Springs
Mitchell, Carl A. ... Benton Harbor
Moore, T. Scott ... Niles
Neville, J. William ... Benton Harbor
Ozeran, C. J. ... Benton Harbor
Pritchard, H. M. ... Niles
Reagan, Robert E. ... Benton Harbor
Rein, Gerald ... Benton Harbor
Rice, Franklin ... Niles
Richmond, D. M. ... St. Joseph
Ruth, J. Griswold ... Benton Harbor
Smith, W. A. ... Berrien Spring
Sowers, Bouton ... Benton Harbor
Strayer, J. C. ... Buchanan
Thorun, D. W. ... Benton Harbor
Tompkins, C. E. ... Benton Harbor
Waterson, Roy S. ... Niles
Westervelt, H. O. ... Benton Harbor
Winter, Joseph A. ... St. Joseph
Woodford, H. E. ... Benton Harbor
Yeomans, T. G. ... St. Joseph

Branch County

Andrews, Frank A. ... Coldwater
Atkinson, A. L. ... Quincy
Bailey, J. E. ... Coldater
Beck, Perry C. ... Bronson
Bien, W. J. ... Coldwater
Culver, Bert W. ... Coldwater
Culver, Dean ... Bronson
Eberhart, L. L. ... Angola, Ind.
Fraser, R. J. ... Coldwater
Heustis, Albert E. ... Coldwater
Joerin, William ... Coldwater
Leitch, R. M. ... Union City
McLain, R. W. ... Jackson
Meier, H. J. ... Coldwater
Mooi, H. R. ... Coldwater
Olmstead, Kenneth L. ... Coldwater
Rees, Kendall B. ... Coldwater
Rennell, E. J. ... Coldwater
Schultz, Samuel ... Coldwater
Thomas, J. A. ... Coldwater
Wade, R. L. ... Coldwater
Walton, N. J. ... Quincy
Weidner, H. R. ... Coldwater
Woods, R. H. ... LaSale, Ill.

Calhoun County

Amos, Norman H. ... Battle Creek
Baribeau, R. H. ... Battle Creek
Becker, H. F. ... Battle Creek
Beuker, Herman ... Marshall
Bodine, Harold R. ... Battle Creek
Bonifer, Philip P. ... Battle Creek
Brainard, C. W. ... Battle Creek
Campbell, Alice ... Albion
Campbell, R. J. ... Battle Creek
Capron, Manley J. ... Battle Creek
Carney, Ruth C. ... Battle Creek
Church, Starr K. ... (E) Marshall
Chynoweth, W. R. ... Battle Creek
Cooper, J. E. ... Battle Creek
Curry, Robert K. ... Homer
Dickson, A. R. ... Battle Creek
Dodge, Warren M. ... Battle Creek
Fairbanks, Stephen ... Albion
Finch, D. L. ... Battle Creek
Forsyth, J. F. ... Albion
Fraser, R. H. ... Battle Creek
Funk, L. D. ... Athens
Gething, Joseph W. ... Battle Creek
Giddings, A. M. ... Battle Creek
Gilfillan, Margery J. ... Battle Creek
Gorsline, Clarence S. ... Battle Creek
Graubner, F. L. ... Marshall
Hansen, Harvey C. ... Battle Creek
Haughey, Wilfrid ... Battle Creek
Heald, C. W. ... Battle Creek
Henderson, Louis M. ... Albion
Henderson, Philip ... Albion
Herzer, Henry A. ... Albion
Hibbs, Donald K. ... Battle Creek
Hills, C. R. ... Battle Creek
Hollands, Robert A. ... Battle Creek
Holtom, B. G. ... Battle Creek
Howard, W. L. ... Battle Creek
Hoyt, Aura A. ... Battle Creek
Hubly, James W. ... Battle Creek
Humphrey, Archie E. ... Marshall
Humphrey, Arthur A. ... Battle Creek
Jeffrey, J. R. ... Battle Creek
Jesperson, Lydia ... Battle Creek
Jones, T. K. ... Marshall
Keagle, Leland R. ... Battle Creek
Keeler, K. B. ... Albion
Kinde, M. R. ... Battle Creek
Kingsley, Paul C. ... Battle Creek
Knapp, Nettie E. ... Battle Creek
Kolvoord, Theodore ... Battle Creek
LaFrance, N. Francis ... Battle Creek
Lam, Francis ... Battle Creek
Levy, Joseph ... Battle Creek
Lewis, W. B. ... Battle Creek
Lowe, H. M. ... Battle Creek
Lowe, Kenneth H. ... Battle Creek
Lowe, Stanley T. ... Battle Creek
MacGregor, Archibald E. ... Battle Creek
Manni, Lawrence C. ... Battle Creek
Meister, F. O. ... Battle Creek
Melges, F. J. ... Battle Creek
Mercer, C. M. ... Battle Creek
Morrison, Donald ... Battle Creek
Moshier, Bertha ... (R) Battle Creek
Mullenmeister, H. F. ... Battle Creek
Mustard, Russell ... Battle Creek
Norton, Richard C. ... Detroit
Patrick, Gilbert ... Battle Creek
Pearson, Donald J. ... Battle Creek
Putnam, W. N. ... Battle Creek
Robbert, John ... Battle Creek
Robins, Hugh ... Battle Creek
Rorick, Wilma Weeks ... Battle Creek
Rosenfeld, Joseph E. ... Battle Creek
Royer, C. W. ... Battle Creek
Schelm, George W. ... Battle Creek
Schwarz, Frank W. ... Battle Creek
Selmon, Bertha L. ... Battle Creek
Sharp, A. D. ... Albion
Shipp, L. P. ... Battle Creek
Sibilsky, A. Clark ... Battle Creek
Simpson, Robert S. ... Battle Creek
Slagle, George W. ... Battle Creek
Sleight, James D. ... Battle Creek
Stadle, Wendell H. ... Battle Creek
Stiefel, Richard ... Battle Creek
Strohmenger, Frank J. ... Albion
Tannenholz, Harold S. ... Battle Creek
Taylor, Clifford B. ... Albion
Toms, Roland E. ... Brooklyn, N. Y.
Upson, W. O. ... Battle Creek
Van Camp, Elijah ... Battle Creek
Vander Voort, W. V. ... Battle Creek
Verity, Lloyd E. ... Battle Creek
Walker, Charles S. ... Battle Creek
Walters, F. R. ... Battle Creek
Wencke, Carl G. ... Battle Creek
Winslow, Rollin C. ... Battle Creek
Winslow, Sherwood B. ... Battle Creek
Zindler, George A. ... Battle Creek

Cass County

Adams, U. M. ... Marcellus
Clary, R. J. ... Dowagiac
Hickman, John ... Dowagiac
Kelsey, James H. ... Cassopolis
Loupee, S. L. ... Dowagiac
Lyman, W. R. ... Dowagiac
Newsome, Otis ... Cassopolis
Pierce, Kenneth C. ... Dowagiac
Zwergel, E. H. ... Cassopolis

Chippewa-Mackinac Counties

Abbiss, Frederick J. ... Sault Ste. Marie
Bandy, F. C. ... Sault Ste. Marie
Carr, E. S. ... Pickford
Finlayson, D. D. ... Sault Ste. Marie
Goldberg, A. H. ... Sault Ste. Marie
Hagele, Marie A. ... Sault Ste. Marie
Harrington, H. M. ... Sault Ste. Marie
Harris, D. M. ... Sault Ste. Marie
Howe, D. C. ... Sault Ste. Marie
Howe, Gertrude ... Sault Ste. Marie
McBryde, Lyman M. ... Sault Ste. Marie
Mertaugh, W. F. ... Sault Ste. Marie
Montgomery, B. T. ... Sault Ste. Marie
Thompson, T. W. ... Sault Ste. Marie
Trapasso, T. G. ... Sault Ste. Marie
Wallen, LeRoy J. ... Sault Ste. Marie
Willison, C. ... (E) Sault Ste. Marie
Yale, I. V. ... Sault Ste. Marie

Clinton County

Cook, Bruno ... Westphalia
Elliott, Bruce R. ... Ovid
Foo, Charles T. ... St. Johns
Frace, Guy H. ... St. Johns
Henthorn, A. C. ... St. Johns
Ho, Thomas Y. ... St. Johns
Luton, F. E. ... St. Johns
McWilliams, W. B. ... Maple Rapids
Miller, Charles Scott ... Fowler
Russell, Sherwood R. ... St. Johns
Stoller, R. Paul ... Fowler
Wahl, George Edward ... St. Johns

Delta-Schoolcraft Counties

Bernier, A. Barrso ... Nahma
Benson, G. W. ... Escanaba
Boyce, D. H. ... Escanaba
Brenner, Ervin J. ... Manistique
Carlton, A. J. ... Escanaba
Chenoweth, Nancy R. ... (E) Escanaba
Defnet, Harry John ... Escanaba
Diamond, J. A. ... Gladstone
Frenn, N. J. ... Bark River
Fyvie, James ... Manistique
Groos, Harold Quinten ... Escanaba
Groos, Louis P. ... Escanaba
Hult, Otto S. ... Gladstone
Lemire, Wm. A. ... Escanaba
Lindquist, N. L. ... Escanaba
McInerney, Thomas A. ... Escanaba
Miller, Albert H. ... Gladstone
Moll, G. W. ... Escanaba
Shaw, George A. ... Manistique
Walch, J. J. ... Escanaba

Dickinson-Iron Counties

Addison, E. R. ... Crystal Falls
Alexander, W. H. ... Iron Mountain
Boyce, George H. ... Iron Mountain
Browning, James L. ... Iron Mountain
Cooper, C. A. ... Stambaugh
Fiedling, Wm. ... Norway
Frederickson, Geron ... Iron Mountain
Huron, W. H. ... Iron Mountain
Irvine, L. E. ... Iron River
Kofmehl, Wm. J. ... Stambaugh
McEachran, Hugh D. ... Iron Mountain
Menzies, Clifford ... Iron Mountain
Palm, E. Theodore ... Crystal Falls
Retallack, R. C. ... Iron River
Smith, Donald R. ... Iron Mountain
Steinke, Charles G. ... Iron Mountain
Wetterstroem, R. G. ... Stambaugh

Eaton County

Arner, Fred Levi....Bellevue
Brown, B. Philip....Cbarlotte
Engle, Paul....Olivet
Goff, S. B....Eaton Rapids
Hannah, H. W....Cbarlotte
Harrod, Gordon....Grand Ledge
Huber, Chas. D....Charlotte
Huyck, Stanhope Pier....Sunfield
Imtbun, Edgar F....Grand Ledge
Meinke, Albert....Eaton Rapids
Myers, Albert W....Potterville
Sevener, Lester G....Charlotte
Stucky, Geo....Charlotte
Van Ark, Bert....Eaton Rapids
Van Ark, Herman....Eaton Rapids
Whitlock, S. C....Dimondale
Willits, C. O....Charlotte

Genesee County

Adams, Chester....Grand Blanc
Anderson, Harley H....Mt. Morris
Andrews, N. A. C....Flushing
Anthony, Geo. E....Flint
Backus, Glenn R....Flint
Baird, James....(E) Flint
Baird, W. C....Flint
Bald, Frederick W....Flint
Barbour, Fleming A....Flint
Baske, Franklin....Flint
Bateman, L. G....Flint
Benson, J. C....Flint
Benson, John C., Jr....Flint
Bernstein, Eli N....Flint
Beyer, Damon P....Clio
Biggar, H. R....Flint
Bishop, D. L....Flint
Blakeley, A. C....Flint
Bogart, Leon M....Flint
Boles, William P....Flint
Bonathan, Alvin T....Flint
Bradley, Robert....Flint
Brain, R. Gordon....Flint
Branch, Hira E....Flint
Brasie, Donald R....Flint
Briggs, Guy D....Flint
Bruce, Wm. W....Swartz Creek
Buchanan, W. Fremont....Fenton
Burkett, L. V....Flint
Burnell, Max....Flint
Burnside, Howard B....Flint
Caster, E. Wilbur....Huntington Woods
Chambers, Myrton S....Flint
Chandler, M. E....Flint
Charters, John H....Flint
Clark, Clifford P....Flint
Clift, M. William....Flint
Colwell, C. W....Flint
Connell, J. T....Flint
Conover, G. V....Flint
Conover, McClellan....Flint
Conover, T. S....Flint
Cook, Henry....Flint
Covert, F. L....Gaines
Crane, Harley C....Flint
Credille, B. A....Flint
Curry, George....Flint
Curtin, J. H....Flint
Cutler, G. Campbell....Flint
David, T. George....Flint
Del Zingro, N....Davison
Denholm, Nan H....Flint
Dickstein, Bernard....Flint
Dimond, E. G....Flint
Dodds, F. E....Flint
Edgerton, A. C....Clio
Eichhorn, Ernest....Flint
Eickhorst, Thomas N....Flint
Elliott, H. B....Flint
Ettinger, Ralph D....Fenton
Evers, J. W....Flint
Farhat, M. M....Flint
Fee, Manson G....Flint
Finkelstein, T....Flint
Flynn, S. T....Flint
Foley, S. I....Flint
Fuller, H. T....Mt. Morris
Gelenger, Stephen M....Flint
Gleason, N. Arthur....Flint
Golden, H. Maxwell....Flint
Goodfellow, B. T....Flint
Gorne, S. S....Flint
Griffin, Ernest P....Flint
Grover, H. F....Flint
Guile, Earl....Flint
Guile, G. S....Flint
Gundry, G. L....Grand Blanc
Gutow, I....Flint
Gutow, J. J....Flint
Hague, R. F....Flint
Hall, R. F....Flint
Halligan, Raymond S....Flint
Hamady, Rutb....Flint
Hamilton, A. J....Flint
Harper, A. W....Flint
Harper, Homer....Flint
Hawkins, James E....Flint
Hays, George A....Flint
Hiscock, H. H....Flint
Hooper, Kendall....Flint
Houston, James....(L) Swartz Creek
Hubbard, Wm. B....Flint
Hufton, Wilfred L....Flint
Jermstad, Robert J....Flint
Johnson, Arthur H....Flint
Johnson, Frank D....Flint
Jones, Lafon....Flint
Kaleta, Edward....Flint
Kaufman, Lewis D....Flint
Knapp, M. S....(R) Fenton
Knapp, Wm. D....Flint
Kretchmar, A. H....Flint
Kurtz, J. J....Flint
Lambert, L. A....Flint
Leach, J. L....Flint
Livesay, Jackson E....Flint
Logan, G. W....Flushing
MacDuff, R. B....Flint
MacGregor, D. M....Flint
Macksood, Josepb....Flint
Marsh, H. L....Flint
Marshall, William H....Flint
McArthur, A....Flint
McGarry, R. A....Flint
McKenna, O. W....(E) Flint
McLeod, K. W. A....Flint
Miller, Loren Eugene....Flint
Miltich, Anthony J....Flint
Moore, Kenneth B....Flint
Morrish, Ray S....Flint
Morrissey, V. H....Flint
Mosier, Edward C....Otisville
Odle, Ira....Flint
Olson, James A....Detroit
O'Neil, C. H....(R) Deckerville
Orr, J. Walter....Flint
Phillips, R. L....Flint
Pfeifer, A. C....Mt. Morris
Pratz, O. C....Flint
Preston, Otto....Flint
Probert, C. C....Flint
Randall, H. E....Flint
Rawlings, J. Mott....Flint
Reeder, Frank E....Flint
Reichard, Orill....Flint
Reid, Wells C....Goodrich
Reynolds, A. J....Flint
Ricbeson, V....Flint
Rieth, George F....Flint
Roberts, Floyd A....Flint
Rowell, Wilfred J....Flint
Rowley, James A....Flint
Rulney, Max....Flint
Rundles, Walter Z....Flint
Rynearson, W. J....Fenton
Sandy, K. R....Flint
Scavarda, Charles J....Flint
Schiff, B. A....Flint
Scott, R. D....Flint
Searles, Karl F....Flint
Shantz, L. O....Flint
Sheeran, Daniel H....Flint
Shipman, Cbarles W....Flint
Sirna, Anthony R....Flint
Sleeman, Blytbe R....Linden
Smith, D. C....Flint
Smitb, E. C....Flint
Smith, Maurice J....Flint
Sniderman, Benjamin....Flint
Snyder, Charles E....Swartz Creek
Sorkin, Morris L....Flint
Sorkin, S. S....Flint
Sparks, Harvey D....Flint
Stephenson, Robert A....Flint
Steinman, F. H....Flint
Stevenson, W. W....Flint
Streat, R. W....Flint
Stroup, C. K....Flint
Sutherland, James K....Flint
Sutton, George....Flint
Sutton, M. R....Flint
Thompson, Alvin....Flint
Tofteland, Elmer H....Flint
Treat, D. L....Flint
Trumble, G. W....Flint
Vander Slice, David....Flint
Van Gorder, George....Davison
Vary, Edwin P....Flint
Walcott, C. G....Fenton
Ward, Nell....Flint
Ware, Frank A....Flint
Wark, D. R....Flint
Wentworth, John E....Flint
Werness, Inga W....Flint
Westcott, George F....Goodrich
White, Carl H....Fenton
White, Herbert....Flint
Williams, W. S....Flint
Willoughby, G. L....Flint
Willoughby, L. L....Flint
Wills, T. N....Flint
Woughter, Harold W....Flint
Wright, D. R....Flint
Wyman, J. S....Flint

Gogebic County

Albert, S. G....Ironwood
Anderson, Chas. E....Bessemer
Eisele, D. C....Ironwood
Franck, J. R....Wakefield
Gertz, M. A....Ironwood
Gingrich, Wayne A....Ironwood
Gorrilla, A. C....Ironwood
Lieberthal, M. J....Ironwood
Lieberthal, Paul....Ironwood
Lojacono, Salvatore....Ironwood
Maccani, Wm. L....Ironwood
Nezworski, H. T....Ironwood
O'Brien, A. J....Ironwood
Pierpont, D. C....Ironwood
Pinkerton, H. A....Ironwood
Stevens, Chas. E....Ironwood
Tressel, H. A....Wakefield
Urquhart, C. C....Ironwood
Wacek, W. H....Ironwood

Grand Traverse-Leelanau-Benzie Counties

Baker, Dorothy M....Traverse City
Beall, John G....Traverse City
Bergborst, John....Traverse City
Bolan Ellis J....Suttons Bay
Brownson, Jay J....Kingsley
Brownson, Kneale M....Traverse City
Busbong, B. B....Traverse City
Evseef, George S....Traverse City
Ellis, Claude I....Suttons Bay
Gallagher, W. H....Traverse City
Gauntlett, J. W....Traverse City
Goodrich, Dwight....Traverse City
Grawn, F. A....Ypsilanti
Hall, James W....Traverse City
Hamilton, Earl E....Traverse City
Haynes, H. B....Traverse City
Huene, Nevin....Traverse City
Huston, Russell R....Elk Rapids
Hyslop, Wm. T....Traverse iCty
Jerome, Jerome T....Traverse City
Kyselka, H. B....Traverse City
Lemen, Cbas. E....Traverse City
Lentz, R. J....Traverse City
Lossman, R. T....Traverse City
Manwaring, John T....Traverse City
Meng, Ralph H....Traverse City
Mumby, Clinton J....Traverse City

Nickels, M. M.....Traverse City
Osterhagen, H. F.....Traverse City
Osterlin, Mark.....Traverse City
Pike, Donald.....Traverse City
Power, Frank H.....Traverse City
Sheets, R. Philip.....Traverse City
Sladek, E. F.....Traverse City
Stone, Fordyce.....Beulah
Swartz, F. G.....Traverse City
Tbacker, Fred R.....Frankfort
Thirlby, E. L.....Traverse City
Trautman, Frederick B.....Frankfort
Van Leuven, B. H.....Traverse City
Way, Lewis R.....Traverse City
Weitz, Harry.....Traverse City
Whitebouse, John D.....Traverse City
Wilcox, Paul H.....Traverse City
Zielke, I. H.....Traverse City
Zimmerman, J. G.....Traverse City

Gratiot-Isabella-Clare Counties

Aldrich, Alfred L.....Itbaca
Barstow, D. K.....St. Louis
Barstow, Wm. E.....St. Louis
Becker, Myron G.....Edmore
Budge, M. J.....Itbaca
Burch, L. J.....Mt. Pleasant
Burt, C. E.....Ithaca
Carney, T. J.....Alma
Davis, L. L.....Mt. Pleasant
Drake, Wilkie M.....Breckenridge
DuBois, C. F.....Alma
Elliott, L. E.....Edmore
Graham, B. J.....Alma
Hall, B. C.....Pompeii
Hammerberg, Kuno.....Clare
Harringan, Wm. L.....Mt. Pleasant
Hobbs, A. D.....St. Louis
Hyslop, Leland F.....Mt. Pleasant
Johnson, P. R.....Mt. Pleasant
McArthur, Stewart C.....Clare
Miller, S. W.....Alma
Oldham, E. S.....Breckenridge
Putzig, Louis M.....Blanchard
Rondot, E. F.....Lake
Rottschafer, J. L.....Alma
Silvert, P. P.....Vestaburg
Strange, Russell H.....Mt. Pleasant
Waggoner, R. L.....St. Louis
Wilcox, R. A.....Alma
Wilson, Earl C.....Harrison
Wolfe, Kenneth P.....Alma
Wood, Cornelius B.....Mt. Pleasant

Hillsdale County

Bates, Morton.....Hillsdale
Davis, L. A.....Montgomery
Day, Luther W.....Jonesville
Douglas, E. W.....Hillsdale
Green, B. F.....Hillsdale
Hanke, Geo. R.....Ransom
Hodge, C. L.....Reading
Hughes, Henry F.....(L) Hillsdale
Jobnson, C. E.....St. Louis, Mo.
Kline, Fred D.....Litchfield
MacNeal, John A.....Hillsdale
Martindale, E. A.....(L) Hillsdale
Mattson, H. F.....Hillsdale
McFarland, O. G.....North Adams
Miller, Harry C.....(L) Hillsdale
Moewch, Geo. F.....Hillsdale
Sawyer, Walter W.....Hillsdale
Strom, A. W.....Hillsdale
Wiggings. I. W.....Jonesville

Houghton-Baraga-Keweenaw Counties

Acocks, J. R.....Houghton
Aldrich, A. B.....Houghton
Aldrich, Addison D.....Houghton
Aldrich, Leonard.....Hancock
Bourland, Phillip D.....(L) Calumet
Brewington, George F.....(E) Mohawk
Burke, John.....Hubbell
Conrad, George A.....Houghton
Gregg, W. T. S.....(E) Calumet
Hillmer, R. E.....Beacon Hill
Hosking, Frederick S.....Calumet
Janis, A. J.....Hancock
King, Wm. T.....Ahmeek
Kirton, Joseph R. W.....Calumet
Kolb, F. E.....Calumet
LaBine, Alfred.....Houghton
Levin, Simon.....Houghton
MacQueen, Donald K.....(E) Laurium
Manthei, W. A.....Lake Linden
McClure, Robert James.....Calumet
Murphy, Percy C.....Calumet
Quick, James B.....(L) Laurium
Roberts, Melvin D.....Hancock
Roche, A. C.....Calumet
Roche, Andrew M.....Calumet
Sarvela, H. L.....Hancock
Scott, Benton V. D.....Houghton
Sloan, P. S.....Houghton
Smith, Charles R.....Hougbton
Stahr, H. S.....Modesta, Calif.
Stern, Isadore D.....Houghton
Tinetti, Ernest F.....Laurium
Wbitmore, R. C.....Hancock
Wickliffe, T. P.....Calumet
Winkler, Henry J.....L'Anse
Wood, Neal N.....Calumet

Huron County

Dixon, R. C.....Pigeon
Gettle, Roy R.....Kinde
Henderson, J. Bates.....Sebewaing
Herrington, Charles I.....Bad Axe
Herrington, Willet J.....Bad Axe
Holdship, Wm. B.....Ubly
Morden, Charles B.....Bad Axe
Oakes, C. W.....Harbor Beacb
Ritsema, John.....Sebewaing
Scheurer, C.....Pigeon
Thumme, Harrison F.....Sebewaing
Weiss, Arno W.....Kinde

Ingham County

Altland, J. K.....Lansing
Bartholomew, Henry S. (R) Harbor Beach
Bauer, Theodore I.....Lansing
Behen, Wm. C.....Lansing
Bellinger, E. G.....Lansing
Black, Charles E.....Williamston
Black, Gertrude.....Williamston
Bobczynski, Wihelmina.....East Lansing
Bradford, C. W.....Lansing
Breakey, Robert S.....Lansing
Briede, Paul C.....Lansing
Brown, F. W., Jr.....Lansing
Brubaker, Earl.....Lansing
Brucker, Karl B.....Lansing
Burbans, Robert.....Lansing
Calomeni, Anthony D.....Detroit
Cameron, W. J.....Lansing
Carr, E. I.....Lansing
Christian, L. G.....Lansing
Clark, William E.....Mason
Clarke, Emilie Arnold.....Lansing
Clinton, George R.....Mason
Cook, R. J.....Lansing
Cope, H. E.....Lansing
Corneliuson, Goldie B.....Lansing
Cowan, John A.....Lansing
Cross, Frank S.....Lansing
Cummings, G. D.....Lansing
Dart, Dorothy.....Lansing
Dean, Carleton.....Lansing
DeKleine, William.....Lansing
DeVries, C. F.....Lansing
Doyle, C. P.....(E) Lansing
Drolett, Fred J.....Lansing
Drolett, Lawrence.....Lansing
Dunn, F. C.....(L) Lansing
Dunn, F. M.....Lansing
Ellis, Bertha.....Lansing
Ellis, C. W.....Lansing
Elmendorf, Edw. N.....Lansing
English, Lena.....East Lansing
Feeney, Kenneth J.....Lansing
Finch, Russell L.....Lansing
Folkers, Leonard M.....East Lansing
Fosget, W. W.....Lansing
Foust, E. H.....Lansing
Galbraith, Dugald A.....Lansing
Gardner, C. B.....Lansing
Goldner, R. E.....Lansing
Hackman, Pearl.....Lansing
Harris, Dean W.....Lansing
Harris, Herbert W.....Lansing
Harrison, W. H.....Lansing
Harrold, J. F.....Lansing
Hart, L. C.....Lansing
Heald, Gordon H.....East Lansing
Heckert, Frank B.....Lansing
Hendren, Owen S.....Birmingham
Henry L. L.....Lansing
Hermes, Ed J.....Lansing
Himmelberger, R. J.....Lansing
Hodges, Kenneth P.....Lansing
Holland, Charles F.....East Lansing
Huggett, Clare C.....Lansing
Huntley, Fred M.....Lansing
Hurth, M. S.....Lansing
Isbister, John L.....Lansing
Johnson, K. H.....Lansing
Jones, Francis A., Sr.....Lansing
Jones, Francis, Jr.....Lansing
Kahn, David.....Lansing
Kalmbach, R. E.....Lansing
Keim, C. D.....Lansing
Kent, Edith Hall.....Lansing
Kent, Herbert K.....Lansing
Kenyon, Fanny H.....Lansing
Klunzinger, Willard R.....Lansing
Lanting, Helen E.....East Lansing
Lanting, Roelof.....Lansing
LeDuc, Don M.....Lansing
Ley, Wilfred.....Lansing
Loree, Maurice C.....Lansing
Lucas, T. A.....Lansing
Ludlum, L. C.....Lansing
Markuson, Kenneth E.....East Lansing
Martin, Wayne O.....Lansing
McConnell, E. G.....(R) Lansing
McCorvie, C. Ray.....East Lansing
McCoy, Earl M.....Grand Ledge
McCrumb, R. R.....Lansing
McElmurry, Leland R.....Lansing
McGillicuddy, Oliver B.....Lansing
McGillicuddy, R. J.....Lansing
McIntyre, J. E.....Lansing
McNamara, B. Edward.....Lansing
McNamara, William E.....Lansing
Meade, Wm. H.....Lansing
Mercer, Walter E.....East Lansing
Miller, H. A.....Lansing
Morrison, C. V.....Lansing
Morrow, R. J.....Lansing
Myers, Victor C.....East Lansing
Ochsner, P. J.....Lansing
O'Sullivan, Gertrude.....(E) Mason
Pinkham, R. A.....Lansing
Place, Edwin H.....Lansing
Ponton, J.....Mason
Prall, H. J.....Lansing
Randall, O. M.....Lansing
Rector, Frank L.....Ann Arbor
Richards, F. D.....DeWitt
Richardson, M. L.....Lansing
Robson, Edmund J.....East Lansing
Rowe, R. E.....East Lansing

Rozan, J. S. ... Lansing
Rozan, M. M. ... Lansing
Russell, Claude V. ... (R) Northport
Sander, John F. ... East Lansing
Sanford, Thomas M. ... (E) Lansing
Schoff, Charles ... Williamston
Seger, Fred L. ... (L) Lansing
Shaw, Milton ... Lansing
Sherman, G. A. ... East Lansing
Sichler, Harper G. ... Lansing
Silverman, Irving E. ... Lansing
Smith, Anthony V. ... Mason
Snell, D. M. ... Lansing
Snyder, LeMoyne ... Lansing
Snyder, Ruth Ellis ... Lansing
Spaulding, Thomas ... Lansing
Spencer, Perry ... Lansing
Stanka, Andrew G. ... Grand Ledge
Stanley, Arthur L. ... Lansing
Steiner, S. D. ... Lansing
Stiles, Frank ... Lansing
Strauss, P. C. ... Lansing
Stringer, C. J. ... Lansing
Swartz, Frederick C. ... Lansing
Tamblyn, F. W. ... Lansing
Toothaker, Kenneth ... Lansing
Trescott, Robert F. ... Lansing
Trimby, Robert H. ... Lansing
Troost, F. L. ... Holt
Vander Zalm, T. P. ... Lansing
Venier, Joseph ... Lansing
Wadley, R. ... Lansing
Webb, Roy O. ... Okemos
Welch, William H. ... Ann Arbor
Wellman, John W. ... Lansing
Wilensky, Thomas ... Lansing
Wiley, Harold W. ... Lansing
Willson, Howard S. ... Lansing
Wilson, Harry A. ... Lansing

Ionia-Montcalm Counties

Bird, Wm. L. ... Greenville
Bracey, L. E. ... Sheridan
Bunce, E. P. ... Trufant
Bunce, Leo ... Trufant
Cook, George Harvey ... Ionia
Dunkin, Lloyd S. ... Greenville
Fleming, J. C. ... Pewamo
Fox, Harold M. ... Portland
Geib, O. P. ... Carson City
Hansen, Carl M. ... Stanton
Hansen, M. M. ... Greenville
Haskell, Robert H. ... Northville
Hoffs, M. A. ... Lake Odessa
Hollard, A. E. ... Belding
Kelsey, L. E. ... Lakeview
Lilly, Isaac S. ... Stanton
Marston, L. L. ... Lakeview
McCann, John J. ... Ionia
Michmerhuizen, Robert E. ... Lake Odessa
Murawa, V. J. ... Ionia
Pankhurst, C. T. ... Ionia
Peabody, C. H. ... Lake Odessa
Reid, Harold E. ... Belding
Rice, Robert E. ... Greenville
Robertson, P. C. ... Ionia
Seidel, Karl E. ... Ionia
Slade, H. G. ... Ionia
Slagh, Milton E. ... Saranac
Snider, J. D. ... Ionia
Socha, Edmund S. ... Ionia
Swift, E. R. ... Lakeview
VanLoo, J. A. ... Belding
Weaver, Harry B. ... Greenville
Whitten, R. R. ... Ionia

Jackson County

Adams, D. C. ... Jackson
Ahronheim, J. H. ... Jackson
Alter, R. H. ... Jackson
Anderson, W. B. ... Jackson
Appel, S. ... Jackson
Baker, G. M. ... Parma
Bartholic, F. W. ... Homer
Beckwith, S. A. ... Stockbridge
Bindshelder, Buell S. ... Jackson
Bullen, G. R. ... Jackson
Chabut, H. M. ... Jackson
Clarke, C. S. ... Jackson
Cochrane, Wayne A. ... Jackson
Cooley, Randall M. ... Jackson
Corley, C. ... Jackson
Corley, Ennis ... Jackson
Cox, Ferdinand ... Jackson
Culver, Guy D. ... Stockbridge
DeMay, C. E. ... Jackson
DeMay, John ... Jackson
Deming, Richard C. ... Jackson
Dengler, C. R. ... Jackson
Durocher, Normand E. ... Jackson
Edmonds, J. M. ... Horton
Enders, W. H. ... Jackson
Filip, H. K. ... Jackson
Finton, Walter L. ... Jackson
Fisher, Joseph V. ... Chelsea
Foust, W. L. ... Grass Lake
Glover, H. G. (R) ... Jackson
Gordon, D. L. ... Jackson
Greenbaum, Harry ... Jackson
Growt, Bowers H. ... Addison
Habenicht, Hilda ... Jackson
Hackett, T. E. ... Jackson
Hackett, Thomas L. ... Jackson
Hanft, Cyril F. ... Springport
Hanna, R. J. ... Jackson
Hardie, G. C. ... Jackson
Harris, Lester J. ... Jackson
Hicks, Glen C. ... Jackson
Holst, John B. ... Jackson
Holstein, A. P. ... Manchester
Hurley, H. L. ... Jackson
Keefer, A. H. ... Concord
Kudner, Don F. ... Jackson
Landron, Daniel ... Michigan Center
Lathrop, Wm. W. (E) ... Jackson
Leahy, E. O. ... Jackson
Lenz, C. R. ... Jackson
Leonard, Clyde A. ... Jackson
Lewis, E. F. ... Jackson
Linden, V. E. ... Jackson
Ludwick, J. E. ... Jackson
McGarvey, W. E. ... Jackson
McLaughlin, M. J. ... Jackson
McLauthlin, Herbert B. ... Jackson
Meads, J. B. ... Jackson
Miller, J. L. ... Jackson
Miller, Samuel L. ... Jackson
Munro, C. D. ... Jackson
Munro, James E. ... Jackson
Munro, Nathan ... Jackson
Murphy, B. M. ... Jackson
Newton, R. E. ... Jackson
Olesky, S. ... Jackson
O'Meara, James J. ... Jackson
Otis, Grant L. ... Jackson
Payne, Andrew K. ... Jackson
Phillips, G. H. ... Jackson
Pier, C. T. ... Brooklyn
Porter, H. W. ... Jackson
Pray, Frank F. ... Jackson
Pray, George R. ... Jackson
Quirk, Edmund J. ... Chelsea
Ransom, F. G. ... Jackson
Rice, John W. ... Jackson
Riley, Philip A. ... Jackson
Roberts, Arthur J. (E) ... Detroit
Sargent, Leland E. ... Jackson
Sautter, William ... Horton
Schmidt, T. E. ... Jackson
Scott, John A. ... Jackson
Shaeffer, A. M. ... Jackson
Sill, Henry W. ... Jackson
Sirhal, Alfred M. ... Brooklyn
Smith, Dean W. ... Jackson
Southwick, W. A. ... Springport
Stewart, L. L. ... Jackson
Stone, Ethon L. ... Jackson
Sugar, Samuel ... Jackson
Susskind, M. V. ... Jackson
Tate, Cecil E. ... Jackson
Taylor, Ross V. ... Jackson
Thayer, E. A. ... Jackson
Thalner, L. F. ... Jackson
Thompson, John R. ... Manchester
Thompson, Tom ... Jackson
Torwick, E. T. ... Jackson
Townsend, J. W. ... Vandercook Lake
Van Schoick, J. D. ... Hanover
Van Schoick, Frank ... Jackson
Van Wagnen, F. I. ... Jackson
Vivirski, Edward E. ... Jackson
Wallace, Warren S. ... Jackson
Wholihan, John W. ... Jackson
Wickham, W. A. ... Jackson
Wilson, N. D. ... Jackson
Winter, G. E. ... Jackson

Kalamazoo County

Aach, Hugo ... Kalamazoo
Andersen, Glenn C. ... Kalamazoo
Alexander, C. A. ... Kalamazoo
Andrews, Sherman ... Kalamazoo
Armstrong, Robert J. ... Kalamazoo
Banner, Lawrence R. ... Kalamazoo
Barak, Herbert G. ... Kalamazoo
Barnebee, J. W. ... Kalamazoo
Behan, Gerald ... Galesburg
Benjamin, Margaret ... Kalamazoo
Bennett, Charles L. ... Kalamazoo
Bennett, Keith ... Kalamazoo
Berry, J. F. ... Kalamazoo
Birch, William ... Kalamazoo
Bodmer, H. C. ... Kalamazoo
Borgman, Wallace ... Kalamazoo
Boys, C. E. ... Kalamazoo
Brown, I. W. ... Kalamazoo
Caldwell, Geo. H. (R) ... Kalamazoo
Cobb, Horace R. ... Kalamazoo
Cook, R. G. ... Kalamazoo
Crane, W. B. ... Kalamazoo
Crawford, Kenneth ... Kalamazoo
Dahlstrom, Doris ... Kalamazoo
Dana, Robert L. ... Kalamazoo
DeGroat, Albert ... Kalamazoo
DenBleyker, Walter ... Kalamazoo
DeWitt, L. H. (R) ... Kalamazoo
De Witt, Norman ... Kalamazoo
Dowd, B. J. ... Kalamazoo
Doyle, F. M. ... Kalamazoo
Ertell, Wm. Francis ... Kalamazoo
Farwell, Byron E. ... Kalamazoo
Fast, R. B. ... Kalamazoo
Fath, August F. ... Kalamazoo
Fopeano, John V. ... Kalamazoo
Fulkerson, C. B. ... Kalamazoo
Fuller, R. T. ... (L) Kalamazoo
Fuller, Paul ... Kalamazoo
Gerstner, Louis ... Kalamazoo
Gilding, Joseph ... Vicksburg
Goodhue, Lolita ... Kalamazoo
Grant, Frederick E. ... Kalamazoo
Green, William ... Kalamazoo
Gregg, Sherman ... Kalamazoo
Hayner, R. A. ... Kalamazoo
Heersma, H. S. ... Kalamazoo
Hildreth, R. C. ... Kalamazoo
Hodgeman, Albert B. ... Kalamazoo
Hoebeke, William G. ... Kalamazoo
Holder, Charles ... Kalamazoo
Howard, H. S. ... Kalamazoo
Howard, W. H. ... Galesburg
Hubbell, R. J. ... Kalamazoo
Huyser, William C. ... Kalamazoo
Irwin, William D. ... Kalamazoo
Jackson, Howard C. ... Kalamazoo
Jackson, John B. ... Kalamazoo
Jennings, W. O. ... Kalamazoo
Kavanaugh, Wm. R. ... Kalamazoo
Kenzie, W. N. (L) ... Richland
Kilgore, Robert Nelson ... Kalamazoo
Klerk, W. J. ... Kalamazoo
Koestner, Paul ... Kalamazoo
Lambert, R. H. ... Kalamazoo
Lavender, Howard ... Kalamazoo
Light, Richard Upjohn ... Kalamazoo
Light, S. Rudolph ... Kalamazoo
Littig, John ... Kalamazoo
MacGregor, J. R. ... Kalamazoo
Machin, H. A. ... Kalamazoo
Malone, James G. ... Kalamazoo
Margolis, Frederick J. ... Kalamazoo
Marshall, Don ... Kalamazoo
Marshall, Evelyn W. ... Kalamazoo
Marshall, William P. ... Kalamazoo
McCarthy, J. S. ... Kalamazoo
McIntyre, Charles H. ... Los Angeles, Calif.
McNabb, A. A. ... Watervliet
Moe, Carl Rex ... Kalamazoo
Morter, Roy A. ... Kalamazoo
Nell, Edward R. ... Kalamazoo
Nibbelink, Benjamin ... Kalamazoo
Olney, H. E. ... Leonidas
Patmos, Martin ... Kalamazoo
Pearson, Edwin O. ... Kalamazoo
Peelen, J. W. ... Kalamazoo

Peelen, Mattbew.....Kalamazoo
Perry, Clifton.....Kalamazoo
Prentice, Hazel R.....Kalamazoo
Prothro. W. B.....Kalamazoo
Pullon, A. E.....Kalamazoo
Rasmussen, Leo.....Visksburg
Rigterink, G. H.....Kalamazoo
Rigterink, H. A. (L).....Kalamazoo
Rockwell, Donald C.....Kalamazoo
Rogers, T. P.....Kalamazoo
Russell, Stuart.....Kalamazoo
Ryan, F. C.....Kalamazoo
Sage, E. D.....Kalamazoo
Scholten, D. J.....Kalamazoo
Scholten, Wm.....Kalamazoo
Schrier, C. M.....Kalamazoo
Schrier, Paul.....Kalamazoo
Schrier, Thomas.....Comstock
Scott, Wm. A.....Kalamazoo
Shackleton, Wm. E. (R).....Kalamazoo
Shook, R. W.....Kalamazoo
Siemsen, W. J.....Kalamazoo
Simpson, B. W.....Kalamazoo
Sisk, W. E.....Kalamazoo
Snyder, Roscoe F. (L).....Kalamazoo
Sofen, Morris B.....Kalamazoo
Southworth, M. N.....Schoolcraft
Stiller, A. F.....Kalamazoo
Stryker, Homer H.....Kalamazoo
Treshlêr, H. J.....Oshtemo
Upjohn, E. Gifford.....Kalamazoo
Upjohn, L. N.....Kalamazoo
Van Urk, Thomas.....Kalamazoo
Verhage, Martin D.....Kalamazoo
Volderauer, John C.....Kalamazoo
Westcott, L. E.....Kalamazoo
Williamson, Edwin M.....Kalamazoo
Wilbur, E. P.....Kalamazoo
Youngs, A. S.....Kalamazoo
Youngs, C. A.....Kalamazoo
Zolen, Margaret.....Kalamazoo

Kent County

Adams, F. A.....Grand Rapids
Aitken, George T.....Grand Rapids
Albers, G. Donald.....Grand Rapids
Alfenito, Felix S.....Grand Rapids
Allen, R. V.....Grand Rapids
Avery, Noyes L.....Grand Rapids
Baert, Geo. H.....(E) Grand Rapids
Baker, Abel J.....Grand Rapids
Ballard, M. S.....Grand Rapids
Balyeat, Gordon W.....Grand Rapids
Barris, Ralph W.....Grand Rapids
Beaton, James H.....Grand Rapids
Beeman, Carl B.....Grand Rapids
Beeman, C. E.....Grand Rapids
Beets, W. Clarence.....Grand Rapids
Bell, Cbarles M.....Grand Rapids
Benjamin, Howard G.....Grand Rapids
Benson, Roland R.....Grand Rapids
Bergsma, Stuart.....Grand Rapids
Beukema, Marenus.....Grand Rapids
Billings, Elton P.....(L) Grand Rapids
Blackburn, Henry M.....Grand Rapids
Bloxsom, Paul W.....Grand Rapids
Boelkins, Richard C.....Grand Rapids
Boet, F. A.....Grand Rapids
Boet, Jobn.....Grand Rapids
Boldyreff, Ephraim.....Grand Rapids
Bosch, L. C.....Grand Rapids
Botting, A. J.....Byron Center
Brace, Fred.....Grand Rapids
Brayman, C. W.....(L) Cedar Springs
Brink, Russell.....Grand Rapids
Brook, Jacob D.....(L) Grandville
Browning, Eugene C.....Grand Rapids
Brotberbood, J. S.....Grand Rapids
Bruggers, Lawrence.....Grand Rapids
Buesing, O. R.....Grand Rapids
Buist, S. J.....Grand Rapids
Bull, Frank L.....Sparta
Burleson, Jobn S.....Grand Rapids
Burling, Wesley M.....Grand Rapids
Burroughs, Frank.....Grandville
Butler, Wm. J.....Grand Rapids
Byers, Earl J.....Grand Rapids
Byrd, Mary Lou.....Grand Rapids
Campbell, Alex. M.....(E) Grand Rapids
Chamberlain, L. H.....(L) Grand Rapids
Chandler, Donald.....Grand Rapids
Clawson, Carroll K.....Grand Rapids
Claytor, R. W.....Grand Rapids
Collisi, Harrison S.....Cleveland, Ohio
Colvin, W. G.....Grand Rapids
Corbus, Burton R.....Grand Rapids
Crane, Charles V.....Grand Rapids
Crane, Harold D.....Grand Rapids
Cuncannan, M. E.....Grand Rapids
Currier, F. P.....Grand Rapids
Dales, Ernest W.....Grand Rapids
Damstra, H. J.....Grand Rapids
Davis, D. B.....Grand Rapids
Dawson, Douglas.....Grand Rapids
Dean, Alfred W.....Grand Rapids
DeBoer, Clarence J.....Ann Arbor
DeBoer, Guy Wm.....Grand Rapids
DeMaagd, Gerald.....Rockford
DeMol, Richard J.....Grand Rapids
Denham, R. H.....Grand Rapids
Denham, Robert H., Jr.....Ann Arbor
DePree, Isla G.....Grand Rapids
DePree, Joseph.....Grand Rapids
Deurloo, H. W.....Grand Rapids
DeVel, Leon.....Grand Rapids
DeVries, Daniel.....Grand Rapids
DeWar, M. M.....Grand Rapids
Dewey, Kent A.....Grand Rapids
DeYoung, Thies.....Sparta
Dick, Mark W.....Grand Rapids
Diskey, Donald.....Grand Rapids
Dixon, Willis L.....Grand Rapids
Doezema, Edward R.....Grand Rapids
Doran, Frank L.....Grand Rapids
Droste, James C.....Grand Rapids
DuBois, Wm. J.....(L) Grand Rapids
Ducey, Edward F.....Grand Rapids
Duiker, Henry.....Grand Rapids
Eaton, Robert M.....Grand Rapids
Eggleston, H. R.....Grand Rapids
Fahlund, George.....Grand Rapids
Failing, Jobn F.....Grand Rapids
Fannaff, Fred L.....Grand Rapids
Farber, Charles E.....Grand Rapids
Faust, L. W.....Grand Rapids
Fellows, Kenneth E.....Grand Rapids
Ferguson, Lynn A.....Grand Rapids
Ferguson, Ward S.....Grand Rapids
Ferrand L.....Rockford
Fitts, Ralph L.....Grand Rapids
Flynn, J. D.....Grand Rapids
Fosbee, J. C.....Grand Rapids
Frantz, Charles H.....Grand Rapids
Freiswyk, Melvin J.....Grand Rapids
Freyling, Robert.....Brooklyn, N. Y.
Fuller, E. H.....Grand Rapids
Gamm, Kenneth.....Grand Rapids
Gibbs, F. F.....Grand Rapids
Gilbert, R. H.....Grand Rapids
Gillett, Frederick S.....Grand Rapids
Grant, Lee O.....Grand Rapids
Grant, Lucile R.....Grand Rapids
Grass, Edward J.....Grand Rapids
Graybiel, George.....Caledonia
Griffith, L. S.....Grand Rapids
Hagerman, D. B.....Grand Rapids
Hammond, T. W.....(R) Grand Rapids
Hayes, L. W.....Howard City
Hayes, Lawrence, Jr.....Howard City
Heetderks, Dewey.....Grand Rapids
Henry, James, Jr.....Grand Rapids
Herrick, Ruth.....Grand Rapids
Hill, A. Morgan.....Grand Rapids
Hodgen, J. T.....Grand Rapids
Holcomb, J. W.....Grand Rapids
Holdsworth, M. J.....Grand Rapids
Holkeboer, Henry D.....Grand Rapids
Hollander, Stephen.....Grand Rapids
House, Glenn W.....Grand Rapids
Hufford, A. R.....Grand Rapids
Huderman, Edward.....Grand Rapids
Hyland, W. A.....Grand Rapids
Jack, William.....Cbicago, Ill.
Jaracz, W. J.....Grand Rapids
Jarvis, Charles.....Grand Rapids
Jellema, J. F.....Grand Rapids
Jones, H. C.....Grand Rapids
Kelly, Edward F.....Grand Rapids
Kelly, Robert E.....Grand Rapids
Kemmer, Thomas R.....Grand Rapids
Kendall, Eugene L.....Grand Rapids
Klaus, C. D.....Grand Rapids
Kniskern, P. W.....Grand Rapids
Kooistra, Henry P.....Grand Rapids
Koon, William D.....Detroit
Kremer, John.....(L) Grand Rapids
Kreulen, H. J.....Grand Rapids
Kriekard, P. J.....(L) Grand Rapids
Krupp, C. G.....Grand Rapids
Laird, Robert G.....Grand Rapids
Lamb, George F.....(L) Grand Rapids
Lanning, N. E.....Grand Rapids
Lentini, Joseph R.....Grand Rapids
Le Roy, Simeon.....Grand Rapids
Lieffers, Harry.....Grand Rapids
Lindenfeld, Frederick H.....Ann Arbor
List, Carl F.....Grand Rapids
Logie, James W.....Grand Rapids
Loranger, Guy L.....Grand Rapids
Lyman, William D.....(L) Grand Rapids
MacDonald, Allen.....Augusta
MacDonell, James A.....Lowell
Marsh, John P.....Grand Rapids
Maurits, Reuben.....(E) Grand Rapids
Maynard, Mason S.....Grand Rapids
McCandliss, Robert.....Grand Rapids
McCormick, John.....Grand Rapids
McDougal, Wm. J.....Grand Rapids
McKenna, J. L.....Grand Rapids
McKinlay, L. M.....Grand Rapids
McRae, John H.....Grand Rapids
Mehney, Gayle H.....Grand Rapids
Miller, J. Duane.....Grand Rapids
Miller, John J.....Marne
Mitchell, H. C.....Grand Rapids
Mitchell, W. B.....Grand Rapids
Moen, Cornetta G.....Grand Rapids
Moleski, Joseph.....Grand Rapids
Moleski, Stanley L.....Grand Rapids
Moll, Arthur M.....Grand Rapids
Morey, Edward C.....Grand Rapids
Mouw, Dirk.....Grand Rapids
Mulder, J. D.....Grand Rapids
Murphy, M. J.....Grand Rapids
Nelson, A. R.....San Francisco, Calif.
Noordewier, Albert.....(L) Grand Rapids
Northouse, Peter B.....Grand Rapids
Notier, Victor.....Grand Rapids
Oliver, W. W.....Grand Rapids
Olson, John R.....Grand Rapids
Osborn, Howard.....Grand Rapids
Patterson, P. Wilfred.....Grand Rapids
Payne, C. Allen.....Grand Rapids
Pearson, Glenn A.....Grand Rapids
Pedden, J. R., Jr.....Grand Rapids
Posthuma, A. E.....San Antonio, Texas
Posthuma, Millard.....Ann Arbor
Postma, Edward Y.....Grand Rapids
Pyle, Henry J.....Grand Rapids
Ragsdale, L. V.....Grand Rapids
Ralph, L. Paul.....Grand Rapids
Reed, Torrance.....Grand Rapids
Rigterink, J. W.....Grand Rapids
Riley, G. L.....Grand Rapids
Robb, Charles S.....Grand Rapids
Roberts, Mortimer E.....(E) Grand Rapids
Robinson, Harold C.....Grand Rapids
Rodgers, William L.....Grand Rapids
Rosenzweig, Leonard.....Grand Rapids
Roth, Emil M.....Grand Rapids
Schaubel, Howard J.....Grand Rapids
Schermerborn, L. J.....Grand Rapids
Schnoor, E. W.....Grand Rapids
Schnute, Louise F.....Grand Rapids
Schuitema, Donald.....Grand Rapids
Sculley, Ray E.....Grand Rapids
Sevensma, Elisha S.....Grand Rapids
Sevensma, Eugene S.....Grand Rapids
Sevey, L. E.....Grand Rapids
Shellman, Millard W.....Grand Rapids
Shepard, B. H.....Lowell
Sherwood, J. Vincent.....Grand Rapids
Sidell, Cbester M.....Grand Rapids
Sidell, Richard H.....Grand Rapids
Slemons, C. C.....(L) Grand Rapids
Sluyter, J. S.....Grand Rapids
Smith, A. B.....Grand Rapids
Smith, Edwin M.....Grand Rapids
Smith, Ferris N.....Grand Rapids
Smith, R. Earle.....Grand Rapids
Smith, Robert B.....Grand Rapids
Snyder, Clarence.....Grand Rapids
Southwick, G. Howard.....Grand Rapids
Steffensen, W. H.....Grand Rapids
Stonehouse, G. G.....Grand Rapids
Stover, Virgil E.....Grand Rapids
Stuart, Gerhardus J.....Grand Rapids
Sugg, Cullen E.....Grand Rapids
Sugyama, Titsuo.....Grand Rapids
Sus Strong, Carl A.....Grand Rapids
Swenson, H. C.....Grand Rapids
Swenson, Leland E.....Grand Rapids
Ten Have, J.....Grand Rapids
Tesseine, A. J.....Grand Rapids
Teusink, J. H.....Cedar Springs
Thompson, A. B.....(E) Grand Rapids
Thompson, Athol B.....Grand Rapids
Thompson, Edw.....Grand Rapids
Thompson, Frank D.....Grand Rapids
Thompson, P. L.....Grand Rapids
Tidey, Marcus B.....Grand Rapids
Tiffany, Jos. C.....Grand Rapids
Torgerson, Wm. R.....Grand Rapids
Truog, Clarence P.....Grand Rapids
Van Belois, Harvard J.....Grand Rapids
Van Bree, R. S.....Grand Rapids
Vanden Berg, Henry J.....Grand Rapids
Vander Meer, Ray.....Grand Rapids

Van Duine, H. J. ... Grand Rapids
Van Harn, R. S. ... Grand Rapids
Vann, N. S. ... Grand Rapids
Van Noord, Gelmer A. ... Grand Rapids
Van't Hof, A. ... Grand Rapids
Van Pernis, Paul A. ... Grand Rapids
Van Reken, H. Everett ... Sparta
Van Solkema, Andrew ... Grand Rapids
Van Solkema, Arthur ... Grandville
Van Woerkom, Daniel ... Grand Rapids
Van Zwaluwenburg, Benj. R. ... Grand Rapids
Veldman, Harold E. ... Grand Rapids
Venema, J. R. ... Grand Rapids
Ver Meulen, John ... Grand Rapids
Vis, William R. ... Grand Rapids
Vyn, J. D. ... Grand Rapids
Webber, Jerome ... Grand Rapids
Wedgewood, L. G. ... Grandville
Wells, Merrill ... Grand Rapids
Wenger, A. V. ... Grand Rapids
Wenger, John N. ... Coopersville
Whalen, John ... Oakland, Calif.
Whinery, Joseph B. ... Grand Rapids
Whinery, Joseph F. ... Grand Rapids
Willits, P. W. ... Grand Rapids
Wilson, Wm. E. ... (R) Grand Rapids
Winter, Garrett E. ... Grand Rapids
Wright, Thomas B. ... Grand Rapids
Wurz, John F. ... Grand Rapids
Yegge, J. P. ... Kent City

Lapeer County

Best, Herbert M. ... Lapeer
Bishop, G. C. ... Almont
Burley, David H. ... (E) Almont
Chapin, Clarence D. ... Columbiaville
Dorland, Clarke ... Lapeer
Doty, James R. ... Lapeer
McBride, J. R. ... Lapeer
Merz, Henry G. ... (E) Lapeer
O'Brien, Daniel J. ... Lapeer
Palmer, Fred W. ... Lapeer
Rehn, Adolph T. ... Lapeer
Smith, G. L. ... Imlay City
Thomas, J. Orville ... North Branch
Zemmer, H. B. ... Lapeer
Zolliker, Carl R. ... Imlay City

Lenawee County

Abraham, A. O. ... Hudson
Allen, R. A. ... Adrian
Blair, Thomas H. ... Adrian
Blanchard, L. E. ... Hudson
Blanden, Merwin R. ... Tecumseh
Colhath, W. E. ... Adrian
Claxton, W. T. ... Britton
DeRyke, Gilbert R. ... Adrian
Dickman, Harry M. ... Hudson
Hammel, H. H. ... Tecumseh
Hardy, P. B. ... Tecumseh
Heffron, Charles ... Adrian
Heffron, Howard H. ... Adrian
Helzerman, Ralph F. ... Tecumseh
Hewes, A. B. ... Adrian
Hewes, William ... Adrian
Hinshaw, W. V. ... Adrian
Hornsby, W. B. ... Clinton
Howland, F. A. ... Adrian
Huntley, H. C. ... Adrian
Isley, H. E. ... Blissfield
Jewett, Wm. E., Jr. ... Adrian
Lamley, A. E. ... Blissfield
Loveland, Horace H. ... Tecumseh
MacKenzie, W. S. ... Adrian
Mast, W. H. ... Tecumseh
McCue, Francis J., Jr. ... Adrian
Marsh, R. G. B. ... Tecumseh
Miller, Perry Lynford ... Adrian
Morden, Esli T. ... Adrian
Pasternacki, Arthur S. ... Adrian
Patmos, Bernard ... Adrian
Purfield, Wm. ... Clinton
Raabe, E. C. ... Morenci
Rogers, J. D. ... Adrian
Sayre, Phillip P. ... Onsted
Spalding, A. L. ... Hudson
Stafford, Leo ... Adrian
Tubbs, R. V. ... Blissfield
Van Dusen, C. A. ... Blissfield
Whitehouse, L. ... Morenci
Wynn, G. H. ... Adrian

Livingston County

Coughlin, Florence J. ... Howell
Crandell, Claire H. ... Howell
Duffy, Ray M. ... Pinckney
Finch, E. D. ... Howell
Glenn, Bernard H. ... Fowlerville
Hendren, J. J. ... Fowlerville
Hill, Harold C. ... Howell
Huntington, H. G. ... Howell
Laboe, Edward W. ... Howell
Lieber, R. W. ... Howell
McDowell, Guy Marshall ... Howell
Sigler, Hollis L. ... Howell
Whitehouse, Walter M. ... Howell

Luce County

Boyce, George H. ... Newberry
Campbell, Earl H. ... Newberry
Gibson, Robert E. ... Newberry
Koss, Frank R. ... Newberry
Purmort, William R., Jr. ... Newberry
Surrell, Mathew A. ... Newberry
Swanson, George F. ... Newberry

Macomb County

Allen, Leroy K. ... Roseville
Banting, O. F. ... Richmond
Barker, John G. ... Center Line
Bower, A. B. ... Armada
Brady, Milo J. ... St. Clair Shores
Buckley, D. J. ... Mt. Clemens
Crawford, A. M. ... Romeo
Croman, Joseph M., Jr. ... Mt. Clemens
Croman, Jos. M., Sr. ... (E) Mt. Clemens
Curlett, James E. ... (L) Roseville
Dudzinski, Edmund J. ... New Baltimore
Engels, J. A. ... Richmond
Heine, A. ... Mt. Clemens
Ishey, Edward K. ... Center Line
Jewell, James H. ... Roseville
Juliar, Joseph F. ... Mt. Clemens
Kane, Wm. J. ... Mt. Clemens
Lynch, Russell ... Center Line
Moore, G. F. ... Mt. Clemens
Mulligan, P. T. ... Mt. Clemens
Reichman, Joseph J. ... Mt. Clemens
Reitzel, R. H. ... Mt. Clemens
Revere, J. O. ... Mt. Clemens
Rivard, Charles L. ... Grosse Pointe Woods
Roth, G. E. ... Detroit
Ruedisueli, Clarence A. ... Roseville
Rothman, A. M. ... East Detroit
Salot, R. F. ... Mt. Clemens
Scher, Joseph N. ... Mt. Clemens
Scher, Sydney ... Mt. Clemens
Siegfried, E. G. ... New Haven
Singer, Nelson ... East Detroit
Smith, Milton C. ... Mt. Clemens
Stone, Elizabeth A. ... Romeo
Sturm, Fred A. ... St. Clair Shores
Thompson, A. A. ... Mt. Clemens
Ullrich, R. W. ... Mt. Clemens
Wellard, Henry C. ... New Baltimore
Whitley, Alec ... St. Clair Shores
Wilde, M. M. ... Warren
Wiley, D. Bruce ... Utica
Wolfson, Victor H. ... Mt. Clemens

Manistee County

Grant, C. L. ... Manistee
Hansen, E. C. ... Manistee
Konopa, John F. ... Manistee
Lalime, Ruth E. ... Bear Lake
Lewis, Lee A. ... (E) Manistee
MacMullen, Harlen ... (R) Manistee
Miller, E. B. ... Manistee
Murphy, Frank E. ... Cadillac
Norconk, Ward H. ... Bear Lake
Oakes, Ellery A. ... Manistee
Ogilvie, G. D. ... Manistee
Quinn, Henry M. ... Copemish
Ramsdell, Homer A. ... Manistee
Switzer, Lars W. ... Manistee

Marquette-Alger Counties

Bennett, Arthur K. ... Marquette
Bennett, M. C. ... Marquette
Berry, Robert F. ... Marquette
Bertucci, J. P. ... Ishpeming
Burke, R. A. ... Negaunee
Bottum, Charles N. ... Marquette
Casler, W. L. ... Marquette
Cooperstock, M. ... Marquette
Corcoran, W. A. ... Ishpeming
Drury, Chas. P. ... Marquette
Elizinga, E. R. ... Marquette
Erickson, Arvid W. ... Ishpeming
Fennig, F. A. ... Marquette
Harkin, J. C. ... Marquette
Harsh, R. C. ... Marquette
Hartt, P. P. ... Ishpeming
Hirwas, C. L. ... Marquette
Hornhogen, D. P. ... Marquette
Howe, L. W. ... Marquette
Keskey, George I. ... Marquette
Knudson, George ... Negaunee
Lambert, W. C. ... Marquette
LeGolvan, C. ... Marquette
McCann, Neal J. ... Marquette
Mudge, W. A. ... Negaunee
Narotzky, Archie S. ... Ishpeming
Nicholson, J. B. ... Marquette
Niemi, O. I. ... Marquette
Paine, Raymond Lee ... Negaunee
Paull, Frank O. ... Marquette
Schweinsberg, Sara D. ... Marquette
Serbst, Charles ... Marquette
Sicotte, Isaiah ... Michigamme
Talso, Jacob ... Ishpeming
Van Riper, Paul ... Champion
Waldie, George McLeod ... Ishpeming
Wickstrom, Geo ... Munising
Williams, R. G. ... Ishpeming

Mason County

Blanchette, Victor J. ... Scottville
Comodo, Nicholas M. ... Ludington
Fenneman, Robert J. ... Scottville
Goulet, L. J. ... Ludington
Hoffman, Howard ... Ludington
Hunt, Ivan L. ... Scottville
Lintner, Roy C. ... Ludington
Martin, Wm. S. ... Ludington
Ostrander, R. A. ... Ludington
Paukstis, Charles ... Ludington
Scott, Robert Redvers ... Ludington
Slayhaugh, J. C. ... Ludington

Mecosta-Osceola-Lake Counties

Bruggema, Jacob ... Evart
Chess, Leo F. ... Reed City
Franklin, Benjamin L. ... Remus
Ikovich, Paul ... Reed City
Kilmer, Paul B. ... Reed City
MacIntyre, Donald ... Big Rapids
Merlo, F. A. ... Big Rapids
Nelson, Lorenzo ... Baldwin
Peck, Louis K. ... Lake City
Treynor, Thomas P. ... Big Rapids
White, J. A. ... Big Rapids
Yeo, Gordon H. ... Big Rapids

Medical Society of North Central Counties

Clippert, C. G. ... Grayling
Coulter, Keith Douglas ... Gladwin
Drescher, Geo. A. ... Lewiston
Egle, Joseph L. ... Gaylord
Forney, F. A. ... Gaylord
Harris, Levi A. ... (E) Gaylord
Jardine, Hugh M. ... West Branch
Keyport, C. R. ... Grayling
Martzowka, M. A. ... Roscommon
McDowell, D. B. ... West Branch
McKillop, G. L. ... Gaylord
Palm, Geo. ... Pruddenville
Peckham, Richard ... Gaylord
Peterson, Carl A. ... Phoenix, Ariz.
Stealy, Stanley ... Grayling

Menominee County

Brukhardt, Herman R. ... Menominee
Dewane, F. J. ... Menominee
Flanagan, Clarence B. ... Menominee
Glickman, L. Grant ... Menominee
Heidenreich, John R. ... Daggett
Jones, Wm. S. ... Menominee
Kaye, J. T. ... Menominee
Kerwell, K. C. ... Stephenson
Peterson, A. R. ... Daggett
Sanford, Joseph ... Stephenson
Sawbridge, Edward ... (E) Stephenson
Schroeder, J. M. ... Menominee
Sethney, Henry T. ... Menominee
Towey, J. W. ... Powers

Midland County

Bowsher, Robert E. ... Midland
Bulmer, Dan J. ... Midland
Buskirk, Maurice D. ... Midland
Gay, Harold H. ... Midland
Gordon, Harold L. ... Midland
Grewe, N. C. ... Midland
Hautau, Emily ... Midland
Ittner, Martin ... Midland
Linsenmann, Karl W. ... Midland
MacCallum, Charles ... Midland
Maynard, W. A. ... Coleman
Meisel, Edward H. ... Midland
Pike, Melvin H. ... Midland
Rice, Robert E. ... Midland
Sherk, J. H. ... Midland
Towsley, W. D. ... Midland

Monroe County

Acker, Wm. F. ... Monroe
Ames, Florence ... Monroe
Balk, A. C. ... Monroe
Barker, Vincent L. ... Monroe
Blakey, L. C. ... Monroe
Bond, W. W. ... Monroe
Brancheau, L. T. ... Petersburg
Cigany, Zoltan B. ... Carleton
Dusseau, S. V. ... (E) Erie
Ewing, R. T. ... Monroe
Flanders, J. P. ... Monroe
Frary, R. A. ... Monroe
Gelhaus, Wm. J. ... Monroe
Golinvaux, C. J. ... Monroe
Heffernan, John F. ... Carleton
Hensel, Hilda ... Monroe
Hunter, M. A. ... Monroe
Johnson, A. Esther ... Monroe
Kelso, S. Newton, Jr. ... Ida
Landon, Herbert W. ... Monroe
Long, Edgar C. ... Monroe
Long, Sara ... Monroe
Mather, C. B. ... Monroe
McDonald, T. A. ... Monroe
McGeoch, R. W. ... Monroe
McMillin, J. H. ... Monroe
Meck, H. L. ... Dundee
Newcomer, Sheldon R. ... Monroe
Parmelee, O. E. ... Lambertville
Pinkus, Herman ... Monroe
Reisig, A. H. ... Monroe
Sanger, Emerson J. ... Monroe
Tomlinson, Ledyard ... Newport
Wagar, Spencer ... Rockwood
Williams, Robert J. ... Monroe
Williamson, G. W. ... Dundee

Muskegon County

Anderson, A. J. ... Muskegon
Anderson, Axel W. ... Lakewood Club
August, R. V. ... Muskegon Heights
Barnard, Helen ... Muskegon
Bate, L. C. ... Muskegon
Beers, Charles ... Muskegon Heights
Benedict, A. L. ... Muskegon
Bloom, C. J. ... Muskegon
Boyd, D. R. ... Muskegon
Boyd, John ... Muskegon
Bradshaw, Park S. ... Muskegon
Christophersen, J. W. ... Muskegon
Clapp, Henry W. ... Muskegon
Closz, H. F. ... Muskegon
Cohan, Sol G. ... Muskegon
Dasler, A. F. ... Muskegon
Derezinski, Clement F. ... Muskegon
Diskin, Frank ... Muskegon
Douglas, Robert ... Muskegon
Durham, C. J. ... Muskegon
Dykhuisen, Harold D. ... Muskegon
Eckerman, C. T. ... Muskegon
Fillingham, Enid ... Muskegon
Fleisch, C. B. ... Muskegon
Fleishman, Norman ... Muskegon
Foss, Ed. O. ... Muskegon
Gaikema, E. W. ... Muskegon
Garher, F. W., Jr. ... Muskegon
Garland, J. O. ... Muskegon
Gillard, James ... Muskegon
Goltz, Martha ... Montague
Greene, Henry Phillip ... Muskegon
Griffith, Robert M. ... Muskegon
Hagen, William A. ... Muskegon
Hannum, F. W. ... Muskegon
Harrington, A. F. ... Muskegon
Harrington, R. J. ... Muskegon
Hartwell, S. W. ... Muskegon
Heneveld, Edw. H. ... Muskegon
Heneveld, John ... Muskegon
Holly, Leland E. ... Muskegon
Holmes, Roy Herhert ... Muskegon
Joistad, A. H. ... Muskegon
Kane, Thomas J. ... Muskegon
Kay, Ceceilia ... Muskegon
Keilin, Marie ... Muskegon
Kerr, H. J. ... Muskegon
Lange, E. W. ... Muskegon
Lauretti, Emil ... Muskegon
Laurin, V. Samuel ... Muskegon
Lefevre, Louis ... Muskegon
Lefevre, Wm. M. ... Muskegon
Loder, Leonel Lewis ... Muskegon
Loomis, John L. ... Muskegon
Mandeville, C. B. ... Muskegon
Medema, Paul ... Muskegon
Meengs, M. B. ... Muskegon
Miller, Philip L. ... Muskegon
Morford, F. N. ... Muskegon
Mulligan, A. W. ... Muskegon
Oden, Constantine L. ... Muskegon
Petkus, Antonie ... Muskegon Heights
Pettis, Emmett ... Muskegon
Powers, Lunette ... Muskegon
Price, Leonard ... Muskegon
Pyle, H. J. ... Muskegon
Risk, R. A. ... Muskegon
Risk, Robert D. ... Muskegon
Schollen, W. ... Muskegon Heights
Sears, Richard ... Muskegon
Shehasta, Emil ... Muskegon
Smith, Luther ... Muskegon
Swartout, W. C. ... Muskegon
Teifer, Charles A. ... Muskegon
Thieme, S. W. ... Ravenna
Thornton, E. S. ... Muskegon
Toy, Charles ... Muskegon
Wagenaar, E. H. ... Muskegon
Wiersma, Silas C. ... Muskegon
Wilke, C. A. ... Montague
Williams, E. V. ... Muskegon Heights
Wilson, P. S. ... Muskegon

Newaygo County

Deur, T. R. ... Grant
Geerlings, Lamhert ... Fremont
Geerlings, Willis ... Fremont
Klein, J. Paul ... Fremont
Masters, Brooker L. ... Fremont
Moore, H. R. ... Newaygo
O'Neill, J. W. ... White Cloud
Stryker, O. D. ... Fremont
Tompsett, Arthur C. ... Hesperia
Tompsett, Arthur C., Jr. ... Hesperia

Northern Michigan

Alm, Bernhard T. ... Petoskey
Beuker, Bernard ... East Jordan
Blum, Benj. B. ... Petoskey
Burns, Dean C. ... Petoskey
Chapman, Willis Earle ... (E) Cheboygan
Conkle, Guy C. ... Boyne City
Conti, Joseph ... Petoskey
Conway, Wm. S. ... Petoskey
Duffie, Don Hastings ... Central Lake
Elliott, E. James ... Boyne City
Frank, Gilbert E. ... Harbor Springs
Gervers, J. H. R. ... Bellaire
Grate, L. ... Charlevoix
Hegener, A. J. ... Petoskey
Kennedy, Julien C. ... Cheboygan
Larson, Walter E. ... Cheboygan
Lashmet, Floyd H. ... Petoskey
Lentini, Nicholas ... Cheboygan
Lilga, Harris V. ... Petoskey
Litzenburger, A. F. ... Boyne City
Mayne, Frederick C. ... Cheboygan
McClintock, Robert S. ... Charlevoix
McMillan, Fraley ... Charlevoix
Palmer, Russell ... St. James
Parks, W. H. ... Petoskey
Power, C. J. ... Mackinaw City
Rodgers, John ... Bellaire
Saltonstall, Gilbert B. ... Charlevoix
Stringham, J. R. ... Cheboygan
Trudeau, J. M. ... Cheboygan
Van Dellen, Jerrian ... East Jordan
Weberg, Kathryn ... Petoskey
Wood, George H. ... Onaway

Oakland County

Abbott, V. C. ... Pontiac
Arnkoff, Harry ... Pontiac
Aschenbrenner, Z. R. ... Farmington
Baker, Frederick A. ... Pontiac
Baker, Robert H. ... Pontiac
Bannow, Robert J. ... Pontiac
Barker, Howard B. ... Pontiac
Barrow, Winona M. ... Royal Oak
Bauer, Edward G. ... Pontiac
Bauer, Ernest W. ... Hazel Park
Beattie, W. G. ... Ferndale
Beck, Otto O. ... Birmingham
Berkaw, Kenneth A. ... Birmingham
Blue, Jane ... Pontiac
Boucher, R. E. ... Royal Oak
Buehrig, Robert C. ... Clarkston
Burke, Chauncey G. ... Pontiac
Butler, Samuel A. ... Pontiac
Calhoun, Ethel T. ... Birmingham
Cameron, Donald A. ... Royal Oak
Carr, Wm. H. ... Holly
Christie, Edward ... Pontiac
Christie, J. W. ... Pontiac
Cobb, Leon F. ... Pontiac
Cobb, Thomas H. ... Pontiac
Cole, Marvin ... Pontiac
Collins, Edward F. ... Pontiac
Cooper, Robert J. ... Pontiac
Crissman, Harold C. ... Ferndale
Cudney, Ethan B. ... Pontiac
Dahlgren, Carl ... Keego Harbor
Darling, C. G., Jr. ... Pontiac
Deutsch, Wm. L. ... Huntington Woods
Dobski, Edwin J. ... Pontiac
Ekelund, Clifford T. ... Pontiac
Farnham, Lucius Augustine ... Pontiac
Ferris, Ralph G. ... Birmingham
Fitzpatrick, Francis ... Pontiac
Foust, Earl W. ... Hazel Park
Francis, Donald ... Pontiac
Furlong, Harold A. ... Pontiac
Gaensbauer, Ferdinand ... Pontiac
Gariepy, Bernard F. ... Royal Oak
Gatley, C. R. ... Pontiac
Gatley, L. Warren ... Pontiac
Geib, Ormond D. ... Rochester
Gehringer, Norman F. ... Pontiac
Gerls, Frank B. ... Pontiac
Gibson, Wellington C. ... Milford
Gill, Matthew J. ... Pontiac
Grant, William A. ... Milford
Green, James D. ... Birmingham
Green, Wm. M. ... Pontiac
Hackett, Daniel Jos. ... Pontiac
Haddock, D. A. ... Walled Lake
Halsted, Lee H. ... Farmington
Hammonds, E. E. ... Birmingham
Harvey, Campbell ... Pontiac
Hassberger, J. B. ... Birmingham
Hathaway, Clarence L. ... Lake Orion
Hathaway, William ... Rochester
Henry, Colonel R. ... Ferndale
Hensley, C. B. ... Lake Orion
Howlett, E. V. ... Pontiac
Hoyt, D. F. ... Pontiac
Hubert, John R. ... Pontiac
Hume, T. W. K. ... Auburn Heights
Hunt, Homer H. ... Pontiac
Hurst, Daniel D. ... Pleasant Ridge
Hutchinson, W. G. ... Bloomfield Hills
Kemp, Felix J. ... Pontiac
Kemp, W. Lloyd ... Birmingham
Koehler, William H. ... Royal Oak
Lambie, John S. ... Birmingham
Lambert, Alvin Gerald ... Ferndale
Larson, B. T. ... Pontiac
Lewis, S. M. ... Ferndale
Lockwood, C. E. ... Holly
Mackenzie, O. R. ... Walled Lake
Margrave, Edmund C. ... Royal Oak
Markley, John Martin ... Pontiac
Mason, Robert J. ... Birmingham
McConkie, J. P. ... Birmingham
McEvoy, Francis J. ... Royal Oak
McNeill, H. H. ... Pontiac
Mehas, C. P. ... Pontiac
Mercer, Frank A. ... Pontiac
Merrill, Lionel N. ... Royal Oak
Mershon, R. B. ... Royal Oak
Mitchell, B. M. ... Pontiac
Monroe, John D. ... Pontiac
Morton, James A. ... Pontiac
Neafie, Chas. A. ... Pontiac
Newcomb, Arnold B. ... Berkley
Norup, John ... Berkley
Nosanchuk, Joseph ... Pontiac
Olsen, Richard E. ... Pontiac
Pauli, Theodore H. ... Pontiac
Pelletier, Charles J. ... Hazel Park
Porritt, Ross J. ... Pontiac
Ports, Preston W. ... Farmington
Prather, Frank W. ... Huntington Woods
Prevette, Isaac C. ... Pontiac
Raynale, George P. ... Birmingham
Riggs, Harry L. ... Pontiac
Riker, Aaron D. ... Pontiac
Roehm, Harold ... Birmingham
Rowley, Laurie G. ... Drayton Plains
Russell, Vincent P. ... Royal Oak
Ruva, Joseph ... Pontiac
St. John, Harold A. ... Pontiac
Schlecte, Carl ... Rochester
Schlecte, Eve Miriam ... Rochester
Schuneman, Howard ... Ferndale
Shadley, Maxwell ... Pontiac
Sheffield, L. C. ... Pontiac
Sibley, H. A. ... Pontiac
Simpson, E. K. ... Pontiac
Smith, Carleton A. ... Birmingham
Smith, Donald S. ... Pontiac
Smith, Ellen ... Pontiac
Spencer, Lloyd H. ... Ferndale
Spoehr, Eugene L. ... Ferndale
Spohn, Earl W. ... Royal Oak
Stageman, John Condon ... Pontiac
Stahl, Harold F. ... Oxford
Stanley, Wm. F. ... Ferndale
Starker, Clarence T. ... Pontiac
Steinberg, Norman ... Royal Oak
Stolpman, A. K. ... Birmingham
Sutton, Palmer E. ... Royal Oak
Swickle, Edward F. ... Clawson
Tauber, A. ... Pontiac
Tuck, Raymond G. ... Pontiac
Uloth, Milton J. ... Ortonville
Van Holtern, H. L. ... Pontiac
Wagley, P. V. ... Pontiac
Wagner, Ruth E. ... Royal Oak
Wake, Douglas L. ... Royal Oak
Warner, J. F. ... Pontiac
Watson, Thomas Y. ... Birmingham
Williams, John P. ... Pontiac
Young, Arthur R. ... Pontiac

Oceana County

Flint, Charles ... Hart
Hasty, Willis A. ... Shelby
Hayton, A. R. ... Shelby
Heard, Wm. ... Pentwater
Jensen, Viggo ... Shelby
Munger, L. P. ... Hart
Nicholson, John H. ... Hart
Robinson, W. Gordon ... Hart
Ryan, Wm. J. ... Shelby
Wood, Merle G. ... Hart

Ontonagon County

Bender, Jesse L. ... Mass
Hogue, H. B. ... Ewen
Rubinfeld, S. H. ... Ontonagon
Strong, W. F. ... Ontonagon

Ottawa County

Barrett, C. Dale ... Grand Haven
Beernink, E. H. ... Grand Haven
Bloemendaal, D. C. ... Zeeland
Blomendal, W. B. ... Grand Haven
Boone, Cornelius E. ... Zeeland
Clark, Nelson H. ... Holland
Cook, Carl S. ... Holland
DeVries, H. G. ... Holland
DeYoung, Fred ... Spring Lake
Hager, Ralph ... Hudsonville
Hamelink, M. H. ... Holland
Harms, H. P. ... Holland
Kemme, Gerrit ... Zeeland
Kitchel, John ... Grand Haven
Kitchel, Mary ... Grand Haven
Kools, William Clarence ... Holland
Leenhouts, Abraham ... Holland
Long, C. E. ... Grand Haven
Nichols, Rudolph H. ... Holland
Nykamp, Russell ... Zeeland
Presley, Wm. J. ... Grand Haven
Schalftenaar, A. H. ... Holland
Schrick, Edna C. ... Holland
Ten Have, Ralph ... Grand Haven
Timmerman, E. C. ... Coopersville
Van Appledorn, Chester J. ... Holland
Van Der Berg, E. ... Holland
Vander Velde, O. ... Holland
Wells, Kenneth ... Spring Lake
Westrate, William ... Holland
Winter, John K. ... Holland
Winter, Wm. G. ... Holland
Yonkman, F. F. ... Madison, N. J.

Saginaw County

Ackerman, G. L. ... Saginaw
Anderson, W. K. ... Saginaw
Bagley, U. S. ... Saginaw
Bagshaw, David E. ... Saginaw
Berberovich, T. F. ... Saginaw
Bishop, H. M. ... Saginaw
Brender, Fred P. ... Frankenmuth
Brock, W. H. ... Saginaw
Bruton, Martin F. ... Saginaw
Bucklin, Robert ... Saginaw
Bullington, Bert Montell ... Saginaw
Busch, Frank J. ... Saginaw

Butler, M. G. ... Saginaw
Button, A. C. ... Saginaw
Cady, F. J. ... Saginaw
Cameron, Allen K. ... Saginaw
Campbell, L. A. ... Saginaw
Chisena, Peter R. ... Bridgeport
Clark, Wilbert ... (L) Kenmore, N. Y.
Claytor, A. A. ... Saginaw
Cortopassi, Andre ... Saginaw
Cortopassi, V. E. ... Saginaw
Cory, C. W. ... Saginaw
Curts, James ... Saginaw
Durman, Donald C. ... Saginaw
Ely, C. W. ... Saginaw
Ernst, Arthur R. ... Saginaw
Eymer, Esther ... Saginaw
Gage, David P. ... Saginaw
Galsterer, Edwin C. ... Saginaw
Goman, Louis D. ... Saginaw
Grigg, Arthur ... (E) Saginaw
Grigg, Arthur P. ... Saginaw
Hand, Eugene A. ... Saginaw
Harvie, L. C. ... Saginaw
Helmkamp, H. O. ... Saginaw
Hester, E. G. ... Saginaw
Hill, Victor L. ... Saginaw
Hohn, Fred, Jr. ... Saginaw
Howell, Don M. ... Saginaw
Jaenichen, R. ... Saginaw
James, J. W. ... Saginaw
Jiroch, R. S. ... Saginaw
Jordan, Leo A. ... Saginaw
Kemp, J. N. ... (L) Saginaw
Kempton, R. M. ... Saginaw
Kerr, William ... Saginaw
Kleekamp, H. G. ... Saginaw
Klippen, Arthur J. ... Saginaw
Kowals, F. V. ... Saginaw
Ling, Ernest M. ... Hemlock
Ling, Kenneth C. ... Hemlock
Lohr, O. W. ... Saginaw
Longstreet, Martha L. ... Saginaw
Luger, F. E. ... Saginaw
Lurie, Robert ... Saginaw
Lyle, R. C. ... Bridgeport
MacKinnon, Edwin D. ... Saginaw
MacMeekin, James Ware ... Saginaw
Manning, John E. ... Saginaw
Markey, Jos. P. ... Saginaw
Martzowka, Wm. P. ... Saginaw
Matthews, Harry C. ... Saginaw
Maurer, John A. ... Saginaw
Mayne, Harold ... Saginaw
McKinney, Alex R. ... Saginaw
McLandress, Joshua A. ... Saginaw
Meyer, Henry J. ... Saginaw
Mikan, V. Robert ... Saginaw
Moon, A. R. ... Saginaw
Morgrette, Leonard ... Saginaw
Mudd, Richard D. ... Saginaw
Murpby, Albert P. ... Saginaw
Murray, M. J. ... Saginaw
Nelson, Oscar A. ... Saginaw
Nicholas, Mildred ... Saginaw
Northway, Robert O. ... Saginaw
Novy, F. O. ... Saginaw
Olson, Porter ... Saginaw
Ostrander, Frank W. ... Freeland
Phillips, Homer A. ... Saginaw
Pietz, Frederick ... Saginaw
Pillsbury, Edward A. ... Frankenmuth
Potvin, Clifford D. ... Saginaw
Poole, Frank A. ... (L) Saginaw
Richards, Ned W. ... Saginaw
Richter, Harry J. ... Saginaw
Ryan, M. D. ... (E) Saginaw
Sargent, D. V. ... Saginaw
Sharp, Martin C. ... Saginaw
Sheldon, S. A. ... Saginaw
Siler, Delbert E. ... Saginaw
Skowronski, Casimer A. ... Saginaw
Slack, Walter K. ... Saginaw
Stahly, Edward H. ... Saginaw
Stander, A. C. ... Saginaw
Stewart, George W. ... Saginaw
Thompson, A. B. ... Saginaw
Tiedke, G. E. ... Saginaw
Toshach, C. E. ... Saginaw
Volk, V. K. ... Saginaw
Wallace, Herbert C. ... Saginaw
Westlund, Norman ... Saginaw
Yntema, S. ... Saginaw

Sanilac County

Blanchard, E. W. ... Deckerville
Ellis, N. J. ... Croswell
Gift, W. A. ... Marlette
Hart, R. K. ... Croswell
Lance, Paul E. ... Marlette
Learmont, H. H. ... Croswell
McGunegle, K. T. ... Sandusky
Seager, M. Cole ... Brown City
Tweedie, G. Evans ... Sandusky
Tweedie, S. Martin ... Sandusky
Webster, John C. ... Marlette

St. Clair County

Armsbury, A. R. ... Marine City
Atkinson, C. F. ... Marine City
Attridge, J. A. ... (L) Port Huron
Banting, K. C. ... Port Huron
Battley, J. C. Sinclair ... Port Huron
Beck, Frank K. ... Port Huron
Beer, Joseph F. ... St. Clair
Benjamin, Clayton C. ... Port Huron
Borden, C. L. ... Port Huron
Boughner, W. H. ... Algonac
Bovee, M. E. ... Port Huron
Bowden, W. S. ... Marine City
Brush, Howard O. ... Port Huron
Burke, Ralpb M. ... Port Huron
Burley, Jacob H. ... Port Huron
Callery, A. L. ... (L) Port Huron
Campbell, R. H. ... West Hartford, Conn.
Carey, Lewis M. ... Detroit
Carney, F. V. ... St. Clair
Clyne, B. C. ... Yale
Cooper, T. H. ... Port Huron
DeGurse, T. E. ... Marine iCty
Fitzgerald, E. W. ... Port Huron
Hall, W. E. B. ... Port Huron
Hazeldine, Herbert J. ... Port Huron
Hills, Ricbard W. ... Yale
Holcomb, R. J. ... Marine City
Hoyt, Charles M. ... Port Huron
Kahn, Oscar B. ... Capac
Kesl, Geo. Matthew ... Port Huron
Kirker, F. O. ... St. Clair
Lauridsen, James ... Port Huron
LeGalley, K. B. ... Port Huron
Licker, R. R. ... Port Huron
Ludwig, Claude A. ... Port Huron
Ludwig, F. E. ... Port Huron
Martin, C. S. ... Port Huron
McColl, D. J. ... (E) Port Huron
McColl, Neil J. ... Port Huron
MacPherson, C. A. ... St. Clair
Meredith, E. W. ... Port Huron
Novak, Walter S. ... Port Huron
Patterson, D. Webster ... Port Huron
Pollock, Donald A. ... Yale
Reynolds, Annie E. ... Port Huron
Sanderson, Josepb L. ... Port Huron
Scbaefer, W. A. ... Port Huron
Sites, E. C. ... Port Huron
Thomas, C. F. ... Port Huron
Treadgold, Douglas ... Port Huron
Ware, John R. ... Port Huron
Wass, Henry C. ... St. Clair
Waters, George ... Port Huron
Wetzel, John O. ... Port Huron
Wight, William G. ... Yale

St. Joseph County

Berg, Lawrence A. ... Sturgis
Blood, J. V. ... Three Rivers
Brunson, A. E. ... Sturgis
Braham, Wilbur ... Sturgis
Fiegel, S. A. ... Sturgis
Fortner, R. J. ... Tbree Rivers
Gillespie, E. ... Sturgis
Hoekman, Aben ... Constantine
Holm, Arvid G. ... Three Rivers
Hoyt, Howard P. ... Colon
Miller, C. G. ... Sturgis
Parrish, Marion ... Sturgis
Pennington, H. C. ... White Pigeon
Penzotti, Stanley ... Three Rivers
Porter, C. G. ... Three Rivers
Raisch, Fred J. ... White Pigeon
Reed, Fred R. ... Three Rivers
Sbeldon, J. P. ... Sturgis
Slote, L. K. ... Constantine
Springer, R. A. ... Centerville
Sweetland, G. J. ... Constantine
Tesar, F. J. ... Centerville
Weir, Dale C. ... Three Rivers
Zimont, R. D. ... Constantine

Shiawassee County

Arnold, Alfred L., Jr. ... Owosso
Backe, John C. ... Durand
Bennett, George W. ... Elsie
Brown, Ricbard J. ... Ann Arbor
Buzzard, Walter Davenport ... Chesaning
Chipman, E. M. ... Owosso
Cook, Ernest ... Corunna
Dillon, James ... Perry
Fillinger, W. B. ... Ovid
Harkness, C. A. ... Owosso
Hoshal, Vern L. ... Durand
Hume, Arthur M. ... (E) Owosso
Hume, Harold A. ... Owosso
Janci, Julius ... Owosso
McKnight, E. R. ... Owosso
Merz, W. L. ... Owosso
Parker, W. T. ... Owosso
Pochert, R. C. ... Owosso
Richards, C. J. ... Durand
Shalmark, J. F. ... Owosso
Shepherd, W. F. ... Owosso
Slagh, E. M. ... Elsie
Watts, Fred A. ... Owosso
Weinkauf, W. F. ... Corunna
Weston, C. L. ... Owosso

Tuscola County

Ballard, James H. ... Cass City
Barbour, Harry A. ... Mayville
Bates, George ... (E) Kingston
Berman, Harry ... Millington
Cook, Raymond ... Akron
Dickerson, Willard W. ... Caro
Dixon, Robert L. ... Wahjamega
Donabue, H. Tberon ... Cass City
Flett, Richard O. ... Millington
Gugino, Frank James ... Reese
Hoffman, T. E. ... Vassar
Howlett, R. R. ... Caro
Johnson, O. G. ... Mayville
Kaven, G. H. ... Unionville
Lamberti, Thomas G. ... Caro
Merrill, Elmer H. ... Caro
Morris, Frank L. ... Cass City
Nigg, Herbert L. ... Caro
Pelczar, Walter ... Unionville
Ruskin, D. B. ... Caro
Savage, Lloyd L. ... Caro
Shoemaker, J. ... Vassar
Starmann, Bernard ... Cass City
Swanson, E. C. ... Vassar
Von Renner, Otto ... Vassar

Van Buren County

Boothby, Carl....Hartford
Boothby, F. M....Lawrence
Boothby, Paul R....Lawrence
Bope, William P....Decatur
Buckborough, M. W....South Haven
Diephuis, Bert....South Haven
French, Merle R....Paw Paw
Gano, Avison....Bangor
Giffen, John R....(E) Bangor
Greenman, Newton H....Decatur
Hoyt, W. F....(E) Paw Paw
Itzen, J. F....South Haven
Maxwell, J. Charles....(E) Paw Paw
McFadden, R. I....Bloomingdale
Penoyar, C. L....South Haven
Ralyea, John R....Paw Paw
Roberts, M. S....South Haven
Spalding, R. W....Gobles
Steele, Arthur H....Paw Paw
TenHouten, Charles....Paw Paw
Terwilliger, Edwin....South Haven
Urist, Martin J....South Haven
Young, William R....Lawton

Washtenaw County

Aldrich, Napier S....Ann Arbor
Alexander, John....Ann Arbor
Asher, Wm. M....Ann Arbor
Badgley, Carl E....Ann Arbor
Barker, Paul....Ann Arbor
Barnwell, John B....Washington, D. C.
Barr, A. S....Ann Arbor
Barry, Geo. R....Ann Arbor
Barss, Harold D....Ypsilanti
Bass, Thomas J....Ypsilanti
Bates, Wm. H....Ann Arbor
Bassow, Paul H....Ann Arbor
Bauer, Gerhard H....Ann Arbor
Baugh, R. H....Ypsilanti
Beebe, Hugh M....Ann Arbor
Bell, Margaret....Ann Arbor
Belser, Walter....Ann Arbor
Bethel, Frank Hartstuff....Ann Arbor
Block, Malcolm L....Ann Arbor
Bohne, A. Waite....Ann Arbor
Brace, William M....Ann Arbor
Britton, H. B....Ypsilanti
Brownlee, Wm. M....Ann Arbor
Buscaglia, C. J....Ypsilanti
Buxton, Robert W....Ann Arbor
Camp, Carl Dudley....Ann Arbor
Cawley, Edward P....Ann Arbor
Cochran, William L....Ann Arbor
Coller, Frederick A....Ann Arbor
Conn, Jerome W....Ann Arbor
Coxon, A. Wm....Ann Arbor
Cummings, H. H....Ann Arbor
Curtis, Arthur C....Ann Arbor
DeJong, Russell....Ann Arbor
DeTar, John S....Milan
Dingman, Reed O....Ann Arbor
Dolfin, W. E....Ypsilanti
Donaldson, S. W....Ann Arbor
Duff, Ivan F....Ann Arbor
Engelke, Otto K....Ann Arbor
Everett, Meldon....Ann Arbor
Falls, Harold F....Ann Arbor
Fink, George C....Ann Arbor
Fitzgerald, Thomas D....Ann Arbor
Forsythe, Warren E....Ann Arbor
Fralick, F. Bruce....Ann Arbor
Francis, Thomas, Jr....Ann Arbor
Frost, Lyle W....Ypsilanti
Frye, Carl H....Ann Arbor
Furstenberg, Albert C....Ann Arbor
Ganzhorn, Edwin....Ann Arbor
Gates, John L....Ann Arbor
Gates, Neil A., Jr....Ann Arbor
Goldman, Abe A....Ann Arbor
Gotz, Alexander....Ann Arbor
Gulde, Andros....Chelsea
Haas, Reynold L....Ann Arbor
Hagerman, George W....Ann Arbor
Haight, Cameron....Ann Arbor
Hall, Winston C....Ann Arbor
Hammond, W. W....Plymouth
Handorf, Heinrich Hugo....Northville
Hannum, M. R....Milan
Harris, Bradley M....Ypsilanti
Harris, Scott T....Ypsilanti
Henderson, John W....Ann Arbor
Henry, L. Dell....Ann Arbor
High, Howard C....Ann Arbor
Himler, Leonard E....Ann Arbor
Hodges, Fred J....Ann Arbor
Holt, John F....Ann Arbor
Hoobler, Sibley W....Ann Arbor
House, Frederic B....Ann Arbor
Howard, S. C....Ann Arbor
Hunt, Robert E....Ann Arbor
Jenkins, Daniel E....Ann Arbor
Jimenez, Buenaventura....Ann Arbor
Johnston, Franklin D....Ann Arbor
Kahn, Edgar A....Ann Arbor
Kambly, Arnold H....Ann Arbor
Keeffe, Eugene J....Ann Arbor
Keene, Clifford H....Ann Arbor
Kemper, J. W....Ann Arbor
Kert, Morley J....Ann Arbor
Killins, Charles G....Ann Arbor
Klingman, Theophil....Ann Arbor
Knoll, Leo A....Ann Arbor
La Fever, Sidney L....Ann Arbor
Lampe, Isadore....Ann Arbor
Law, John L....Ann Arbor
Litchty, Dorman E....Ann Arbor
Lowell, Vivion F....Ypsilanti
Lyons, Richard H....Ann Arbor
MacIntyre, Robert S....Ann Arbor
MacKaye, Lavina G....Ann Arbor
Malcolm, Karl D....Ann Arbor
Mallery, Otto T., Jr....Ann Arbor
Marshall, Mark....Ann Arbor
Martin, Donald W....Ypsilanti
Maxwell, James H....Ann Arbor
McCotter, Rollo E....Ann Arbor
McEachern, Thomas H....Ann Arbor
McKay, Clinton H....Charlotte, N. C.
Milford, Albert F....Ypsilanti
Miller, Harold....Saline
Miller, Norman F....Ann Arbor
Moore, Donald F....Ypsilanti
Morrow, Wm. J....Ann Arbor
Muehlig, George F....Ann Arbor
Myers, Dean W....Ann Arbor
Nesbit, Reed M....Ann Arbor
Newton, Chas. W....Ann Arbor
Nickel, Kenneth C....Ypsilanti
Oliphant, L. W....Ann Arbor
Parnall, Christopher G....Ann Arbor
Patterson, Ralph M....Ann Arbor
Peet, Max....Ann Arbor
Pollard, H. M....Ann Arbor
Potter, Marcia....Ypsilanti
Preston, John F., Jr....Ann Arbor
Price, Helen F....Ann Arbor
Prout, Gordon J....Saline
Ransom, Henry....Ann Arbor
Raphael, Theophile....Ann Arbor
Ratliff, Rigdon K....Ann Arbor
Riecker, H. H....Ann Arbor
Riggs, Harold W....Ann Arbor
Ross, C. Howard....Ann Arbor
Sayre, George S....Ypsilanti
Schmale, Herbert T....Ann Arbor
Schreiber, E. O....Ann Arbor
Schumacker, W. E....Ann Arbor
Scovill, H. A....Ypsilanti
Seevers, Maurice H....Ann Arbor
Seime, Reuben I....Ypsilanti
Sheldon, John M....Ann Arbor
Sibbald, Malcolm L....Chelsea
Sink, Emory W....Ann Arbor
Slaughter, John C....Ann Arbor
Slenger, Walforth R....Ypsilanti
Smalley, Marianna....Ann Arbor
Smith, Eleanor....Ann Arbor
Snow, Glenadine....Ypsilanti
Solis, Jeanne C....(E) Ann Arbor
Struthers, J. N. P....Ann Arbor
Sturgis, Cyrus C....Ann Arbor
Sundwall, John....Ann Arbor
Teed, Reed Wallace....Ann Arbor
Thieme, E. Thurston....Ann Arbor
Thomson, Daniel C....Ann Arbor
Towsley, Harry A....Ann Arbor
Waggoner, R. W....Ann Arbor
Waldron, Alexander M....Ann Arbor
Washburne, Charles L....Ann Arbor
Watson, Ernest Hamilton....Ann Arbor
Wessinger, J. A....(E) Ann Arbor
Wile, Udo J....Ann Arbor
Wilkinson, Chas. F....Ann Arbor
Williams, Howard R....Ann Arbor
Williamson, F. B....Ypsilanti
Wilson, Frank N....Ann Arbor
Wisdom, Inez....Ann Arbor
Woods, J. J....Ypsilanti
Worth, Melissa H....Ypsilanti
Wright, Walter J....Ypsilanti
Wylie, Wm. C....Dexter
Yoder, O. R....Ypsilanti

Wayne County

Aaron, Charles D....(E) Detroit
Abbott, William E....Detroit
Abrams, Harry M....Detroit
Abramson, Max....Detroit
Abruzzo, Anthony M....Detroit
Adams, James Robert....Dearborn
Adelson, Sidney L....Detroit
Adler, Sidney....Detroit
Agnew, George H....Detroit
Akroyd, Cecil....Detroit
Albrecht, Herman F....Detroit
Alderman, R. F....Detroit
Aldrich, E. Gordon....Detroit
Alexander, Eugene James....Detroit
Alford, E. S....Belleville
Allen, John V....Lincoln Park
Alles, Russell W....Detroit
Allison, Frank B....Detroit
Allison, Herbert C....Grosse Pointe Farms
Alpiner, Sam....Detroit
Altman, Raphael....Detroit
Altshuler, Abraham M....Detroit
Altshuler, Ira M....Detroit
Altshuler, S. S....Army
Amberg, Emil....(E) Detroit
Amolsch, Arthur L....Detroit
Amos, Thomas G....Detroit
Anderson, Bruce....(L) Detroit
Anderson, Gordon H....Dearborn
Anderson, J. O....Detroit
Anderson, Walter L....Detroit
Anderson, Walter T....Detroit
Anderson, William....Northville
Andries, George G....Detroit
Andries, Joseph H....(L) Detroit
Andries, Raymond C....Detroit
Ankley, J. W....Detroit
Annessa, Dommenico M....Detroit
Anslow, Robert E....Detroit
Appel, Phillip R....Detroit
Appelman, H. B....Detroit
Arehart, Burke W....Detroit
Arent, John G....Detroit
Armstrong, Arthur G....Detroit
Arnold, Effie....Detroit
Aronstam, Noah E....(L) Detroit
Arrington, Robyn J....Detroit
Ascher, Meyer S....Detroit
Ashe, Stilson R....Detroit
Ashley, L. Byron....Detroit
Ashton, F. B....Highland Park
Asselin, Regis F....Detroit
Atchison, Russell M....Northville
Athay, Roland M....Eloise
Atler, Lawrence R....Detroit
Atler, Leroy L....Detroit
Aubel, M. E....Detroit
August, Harry E....Detroit
Auld, Douglas V....Detroit
Avrin, Ira....Detroit
Axelson, A. U....Detroit
Babcock, Kenneth B....Detroit
Babcock, L. K....Detroit
Babcock, Myra E....Detroit
Babcock, W. W....Detroit
Bach, Walter F....Detroit
Bachman, Morris E....Detroit
Bacon, Vinton A....Detroit
Bader, Benjamin H....Detroit
Baer, George J....Detroit
Baer, Raymond B....Detroit
Baeff, Michael A....Detroit
Bagley, Harry E....Dearborn
Bailey, Carl C....Detroit
Bailey, Don A....Detroit
Bailey, John H....Detroit
Bailey, Louis J....Detroit
Bailey, Wm. Arthur....Detroit
Baker, Clarence....Detroit
Bakst, Joseph....Detroit
Balaga, F. T....Detroit

Balberor, Harry....Detroit
Balcerski, Matthew A....Detroit
Ballard, Charles S....Detroit
Balser, Charles W....Detroit
Baltz, James I....Detroit
Barak, Lewis R....Detroit
Baranowski, A. W....Detroit
Barland, Oscar L....Detroit
Barnes, Donald J....Detroit
Barnes, Van D....Detroit
Barnett, Edwin D....Detroit
Barnett, Morton....Detroit
Barnett, Saul E....Detroit
Barone, Charles J....Highland Park
Barrett, Wyman D....Detroit
Barron, William H....Detroit
Bartemeier, Leo H....Detroit
Barton, J. R....Detroit
Bates, Gaylord S....Detroit
Bauer, Benedict J....Detroit
Bauer, A. Robert....Detroit
Bauer, Lester Eugene....Detroit
Baumer, Moe....Detroit
Baumgarten, Elden C....Detroit
Bayles, John G....Detroit
Beach, Watson....Detroit
Beam, A. Duane....Grosse Pointe
Beamer, George D....Dearborn
Beaton, Colin....Detroit
Beattie, Robert....(L) Detroit
Beaver, Donald C....Detroit
Beck, Eva F....Eloise
Becker, Abraham....Detroit
Becker, Joseph Wm....Detroit
Becklein, C. L....Detroit
Beckwitt, M. C....Detroit
Bedell, A....Detroit
Beecher, A. J....Detroit
Beeuwkes, L. E....Dearborn
Behn, Claud W....Detroit
Beigler, Sydney K....Detroit
Belanger, Ernest E....River Rouge
Belanger, Wm. George....Detroit
Belknap, Warren F....Royal Oak
Bell, J. Kenner....Detroit
Bell, William....Detroit
Benjamin, Wm. O....Detroit
Bennett, Germany E....Detroit
Bennett, Harry B....Detroit
Bennett, Sanford A....Detroit
Bennett, Wm. E....Detroit
Bennett, Zina B....Detroit
Benson, C. D....Detroit
Benson, Davis A....Detroit
Benson, Virginia....Detroit
Bentley, Frederick E....Plymouth
Bentley, Neil I....Detroit
Beresh, Louis....Detroit
Berge, Clarence A....Detroit
Bergman, Murray S....Detroit
Bergo, Howard L....Detroit
Berke, Sydney S....Detroit
Berkey, Wm. E....Detroit
Berkman, Ruth....Detroit
Berlien, Ivan C....Detroit
Berman, Lawrence....Detroit
Berman, Robert....Detroit
Berman, Sidney....Detroit
Bernard, Walter G....Detroit
Bernbaum, Bernard....Detroit
Bernstein, Albert E....Detroit
Bernstein, Samuel S....Detroit
Berry, Joseph E....Detroit
Besancon, J. H....Detroit
Best, John W....Detroit
Best, T. H. Edward....Detroit
Bicknell, Edgar A....Detroit
Bicknell, Frank B....Detroit
Bicknell, Nathan J....Detroit
Birch, John R....Detroit
Birkelo, Carl C....Detroit
Birndorf, Leonard....Detroit
Bittker, I. Irving....Detroit
Bittrich, Norbert M....Detroit
Black, Perry S....Detroit
Blain, Alexander, III....Ann Arbor
Blain, Alexander W....Grosse Pointe Park
Blain, James H., Jr....Detroit
Blaine, Max....Detroit
Blair, K. E....Detroit
Blanchet, Alred D....Detroit
Blashill, James B....Detroit
Bleier, Alfred....Detroit
Bleier, Joseph....Detroit
Bloch, Abraham....Detroit
Blodgett, Wm. E....(L) Detroit
Blodgett, William H....Detroit
Bloom, Arthur R....Detroit
Bloomer, Earl....Dearborn
Blumenthal, Franz L....Detroit
Boccaccio, John....Detroit
Boccia, James J....Detroit
Boddie, Lewis F....Detroit
Boddie, Arthur W....Detroit
Boehm, John D....(R) West Branch
Boell, Arthur F....Detroit
Bogue, Robert E....Detroit
Bogusz, Ladislaus....Eloise
Bohn, Stephen....Detroit
Boileau, T. I....Detroit
Bookmyer, R. H....Detroit
Bookstein, Abraham M....Detroit
Borstein, Sidney....Detroit
Bott, Edmund T....Wyandotte
Botvinick, Isadore....Detroit
Boutrous, Thomas A....Detroit
Bovill, E. G....Detroit
Bower, Franklin T....Detroit
Bowers, Leo J....Detroit
Boyd, John H....Trenton
Brachman, D. S....Detroit
Bracken, Andrew H....Dearborn
Bradley, George....Detroit
Bradshaw, Wm. H....Detroit
Brady, Herbert A....River Rouge
Braitman, Louis....Detroit
Braley, W. N....Detroit
Bramigk, Fritz W....Detroit
Brand, Benjamin....Detroit
Brando, Russell G....Detroit
Brandt, Edward L....Detroit
Braun, Lionel....Detroit
Braverman, Morris....Detroit
Brekke, Viola G....Detroit
Breitenbecher, Edw R....Detroit
Bremer, Wm. M....Detroit
Brengle, Deane R....Detroit
Breon, Guy L....Detroit
Briegel, Walter A....Detroit
Brines, O. A....Detroit
Bringard, Elmer L....Detroit
Brisbois, Harold J....Plymouth
Brisson, Joseph....Detroit
Bromme, William....Detroit
Bronson, Wm. W....Detroit
Brooks, A. L....Detroit
Brooks, Clark D....Detroit
Brooks, Charles W....Detroit
Brooks, Nathan....Detroit
Brosius, Wm. L....Detroit
Broudo, Philip H....Detroit
Brough, Glen A....Detroit
Brown, A. O....Detroit
Brown, Andrew G....Detroit
Brown, Carlton F....Detroit
Brown, Charles H....Detroit
Brown, Frances....Detroit
Brown, Gordon T....Detroit
Brown, Harvey F....Detroit
Brown, Henry S....Detroit
Brown, John R....Detroit
Brown, Robert A....Detroit
Brown, Samuel....Detroit
Brown, Stanley H....Detroit
Brown, Thomas A....Detroit
Brownell, Paul G....Detroit
Bruehl, Richard....Detroit
Bruer, Edgar S....Escorse
Bruer, Edwin L....Detroit
Brunk, Andrew S....Detroit
Brunk, C. F....Detroit
Brunke, B. B....Detroit
Brush, Bock Edwin....Detroit
Bryce, John D....Detroit
Buchanan, W. Paul....Detroit
Buck, John D....Detroit
Budson, Daniel....Detroit
Buesser, Frederick G....Detroit
Buller, H. L....Detroit
Burbidge, Earl L....Detroit
Burgess, Charles M....Detroit
Burns, Robert T....Detroit
Burnstine, Julius Y....Detroit
Burnstine, Perry P....Detroit
Burr, George C....Detroit
Burr, H. Leonard....Detroit
Burrows, Howard A....Dearborn
Burstein, Harry S....Detroit
Burstein, I. Marvin....Detroit
Burstein, Morris M....Detroit
Burton, D. T....Detroit
Burton, I. F....Detroit
Bush, Glendon J....Detroit
Bush, Lowell M....Detroit
Butler, Harry J....(L) Detroit
Butler, L. H....Detroit
Butler, Volney N....Detroit
Butterworth, Herman K....Lincoln Park
Buttrum, Edward J....Detroit
Byers, Dudley W....Detroit
Byington, Garner M....Detroit
Cadieux, Henry W....(L) Detroit
Caldwell, J. Ewart....Detroit
Caldwell, George L....Detroit
Calkins, H. N....Detroit
Callaghan, T. T....Detroit
Cameron, A. H....Wyandotte
Cameron, Duncan A....Detroit
Campau, George H....Detroit
Campbell, Charles A....Dearborn
Campbell, Darrell A....Eloise
Campbell, Duncan....Detroit
Campbell, Duncan A....(L) Detroit
Campbell, Malcolm D....Pleasant Ridge
Campbell, Mary B....Detroit
Candler, Clarence L....Detroit
Canter, Allie L....Detroit
Canter, G. E....Detroit
Cantor, M. O....Detroit
Capano, Oreste A....Detroit
Caputo, Joseph M....Dearborn
Caraway, James E....Wayne
Carbone, Louis A....Detroit
Carey, Cornelius....Detroit
Carleton, Lawrence H....Detroit
Carlson, Harold W....Detroit
Carlucci, Peter F....Detroit
Carmichael, E. K....Detroit
Carnes, Harry E....Detroit
Carp, Joseph....Detroit
Carpenter, C. H....Detroit
Carpenter, C. J....Detroit
Carpenter, Glenn B....Detroit
Carpenter, William S....Detroit
Carr, J. G....Detroit
Carroll, E. H....Detroit
Carroll, Lona B....Detroit
Carrick, Lee....Detroit
Carson, Herman J....Detroit
Carter, John M....Detroit
Carter, L. F....Detroit
Cassidy, Wm. J....Detroit
Castrop, C. W....Dearborn
Catherwood, A. E....Detroit
Caton, Dorothy....Detroit
Caughey, E. H....Detroit
Caumartin, Fred E....Detroit
Cavell, Roscoe W....Detroit
Chabut, V. George....Northville
Chall, Henry G....Detroit
Chance, J. H....Detroit
Chapin, Sidney E....Dearborn
Chapman, Aaron L....Detroit
Chapman, Paul T....Detroit
Chapnick, H. A....Detroit
Charnas, Sidney....Detroit
Chase, Clyde H....Detroit
Chatel, Arthur N....Detroit
Chesluk, H. M....Detroit
Chester, W. P....Detroit
Childs, George M....Detroit
Chipman, W. A....Detroit
Chittenden, George E....Detroit
Chittick, Wm. R. (E) Spring Valley, Cal.
Chostner, G. C....Detroit
Christensen, C. A....Dearborn
Christopher, James G....Detroit
Chrouch, Laurence A....Detroit
Church, Aloysius....Detroit
Cioffari, Mario S....Detroit
Ciprian, Joseph E....Detroit
Clark, Benjamin W....Detroit
Clark, C. M....Detroit
Clark, Donald V....Detroit
Clark, George E....(E) Detroit
Clark, Harold E....Detroit
Clark, Harry G....Detroit
Clark, Harry L....Detroit
Clarke, Norman E....Detroit
Clifford, Charles H....Detroit
Clifford, John E....Detroit
Clifford, Thomas P....Detroit
Clippert, J. C....Grosse Ile
Clyde, Ensign....Ann Arbor
Coan, Glenn L....Wyandotte
Coates, Carl Amos....Dearborn
Cobane, John H....Detroit
Cochrane, Edgar G....Detroit
Cohen, H. Herbert....Detroit
Cohn, Daniel E....Detroit
Cohoe, Don E....Detroit
Cole, Fred H....Detroit
Cole, James E....Detroit
Cole, Wyman C. C....Detroit
Coleman, Margarete W....Detroit
Coleman, William G....Redford
Coll, Howard R....Detroit
Collings, M. Raymond....Detroit
Collins, James D....Detroit
Colvert, James R....Detroit
Colvin, Leslie T....Detroit
Colyer, Raymond G....Detroit
Comfort, Milton D....Flat Rock
Comstock, Lawrence....Trenton
Condon, Stanley....Detroit
Conley, L. C. M....Detroit
Conn, Harold....Detroit
Conn, Raymond W....Detroit
Connelly, Richard C....Detroit
Conner, Edward D....Highland Park
Connolly, Frank....Detroit
Connolly, John P....Detroit
Connolly, Paul J....Detroit
Connors, J. J....Detroit
Conrad, E. R....Detroit

Constable, Canute G.....Detroit
Cook, James C.....Dearborn
Cooksey, Warren B.....Detroit
Coolidge, Maria Belle (L)..Grosse Pt. Pk.
Cooper, B. J.....Detroit
Cooper, E. L.....Detroit
Cooper, James B.....Detroit
Cooper, Ralph R.....Detroit
Corbeille, Catherine.....Detroit
Coseglia, Robert P.....Detroit
Cosgrove, Wm. J.....Detroit
Costello, Russell T.....Detroit
Cotruro, L.D.....Detroit
Cotton, S. O.....Detroit
Coucke, Henry O.....Ferndale
Coulter, Wm. J.....Detroit
Courville, Charles J.....Detroit
Cowan, Wilfrid.....Detroit
Cowen, Leon B.....Detroit
Cowen, Robert L.....Detroit
Cowley, Leonard L.....Detroit
Coyne, Douglas R.....Detroit
Crane, Langdon T.....Detroit
Crane, Thomas P.....Dearborn
Crawford, Albert S.....Detroit
Cree, Walter J.....(E) Detroit
Crews, Thomas H.....Detroit
Croll, L. J.....Detroit
Croll, Maurice.....Detroit
Crook, Charles L.....Highland Park
Cross, Harold E.....Detroit
Crossen, Henry F.....Detroit
Croushore, J. E.....Detroit
Cruikshank, Alexander.....(E) Detroit
Culp, Ormond.....Detroit
Curhan, Joseph H.....Detroit
Curry, F. S.....Detroit
Curtis, Frank E.....Detroit
Cushing, Russell G.....Detroit
Cushman, H. P.....Detroit
Cusick, Paul L.....Detroit

Dale, Esther H.....Detroit
Dale, Mark.....Detroit
Danforth, J. C.....Detroit
Danforth, Mortimer E.....Detroit
Daniels, L. E.....Detroit
Darling, Milton A.....Detroit
Darpin. Peter H.....Detroit
Dart, Edward.....Dertoit
Davidow, David M.....Detroit
Davidson, Harry O.....Detroit
Davies, Thomas S.....Detroit
Davies, Windsor S.....Detroit
Davis, Egbert F.....Wyandotte
Davis, George H.....Detroit
Davis, Wm. H.....Detroit
Dawson, F. E.....Detroit
Dawson, Ralph.....Detroit
Dawson, W. A.....Inkster
Day, A. Jackson.....Detroit
Day, J. Claude.....Detroit
Deering, Robert James.....Ecorse
Defever, Cyril R.....Detroit
Defnet, Wm. A.....Detroit
De Jongh, Edwin.....Detroit
Demaray, John F.....Detroit
Demoster, James H.....(L) Detroit
De Nike, A. James.....Detroit
Denis, George M.....Detroit
De Ponio, Sylvester A.....Detroit
Derby, Arthur P.....Detroit
Deresz, Alphonse.....Detroit
Derleth, Paul E.....Detroit
De Rosier, Joseph L.....Detroit
De Spelder, Ray E.....Detroit
De Tomasi, Rome Q.....Detroit
Dibble, Harry F.....Detroit
Dickson, B. R.....Detroit
Dickson, Elias L.....Detroit
Diebel, Nelson W.....Detroit
Dietzel, H. O.....Detroit
Dill, Hugh L.....Detroit
Dill, J. Lewis.....Detroit
Di Loreto, Panfilo C.....Detroit
Dittmer, Edwin.....Detroit
Dixon, Fred W.....Dearborn
Dixon, Ray S.....Detroit
Dixon, Robert K.....Detroit
Dodds, John C.....Detroit
Dodenhoff, C. F.....Detroit
Dodrill, F. D.....Detroit
Doerr, Louis E., Jr.....Detroit
Dolega, Stanley F.....Detroit
Dolman, E. Nesbitt.....Detroit
Domzalski, C. A.....Detroit
Donald, Douglas.....Detroit
Donovan, Daniel R., Jr.....Detroit
Donovan, Richard S.....Detroit
Dorsey, John M.....Detroit
Doty, Chester A.....Detroit
Doub, Howard P.....Detroit
Douglas, Bruce H.....Detroit
Douglas, Clair L.....Detroit
Dovitz, Benjamin W.....Detroit
Dow, Roy E.....Detroit

Dowdle, Edward.....Detroit
Downer, Ira G.....Detroit
Doyle, George H.....Detroit
Drake, Ellet H.....Detroit
Drake, James J.....Detroit
Draves, Edward F.....Detroit
Drews, Robert S.....Detroit
Drinkhaus, Harold I.....Detroit
Droock, Victor.....Detroit
Drummond, Donald L.....Detroit
Dubin, Joseph J.....Detroit
Dubnove, Aaron.....Detroit
Du Bois, Paul W.....Detroit
Dubpurnell, Karl.....(E) Detroit
Dubpernell, Martin S.....Detroit
Duffy, Edward A.....Detroit
Dundas, Edw. M.....Detroit
Dunlap, Henry A.....Detroit
Dunlap, Samson F.....Detroit
Dunn, Cornelius E.....Detroit
Durocher, Edmund J.....Escorse
Dutchess, Charles E.....New York City
Dwaihy, Paul.....Detroit
Dwyer, Francis.....Detroit
Dziuba, John F.....Detroit

Eades, Charles C.....Detroit
Eadie, Gordon A.....Detroit
Eakins, Frederick J.....Detroit
Eaton, Crosby D.....Detroit
Eder, Joseph R.....Detroit
Eder, Samuel J.....Detroit
Edgar, Irving I.....Detroit
Edgar, Russell G.....Detroit
Edmonds, W. N.....Detroit
Edwards, Gilbert L.....Detroit
Edwards, J. W.....Detroit
Eisman, Clarence H.....Detroit
Eldridge, Edward F.....Detroit
Ellias, Elmer P.....Dearborn
Elliott. Wm. G.....Detroit
Elman, Meyer J.....Detroit
Elvidge, Robert J.....Detroit
Emmert, Herman C.....(L) Detroit
Engel, Earl H.....Wyandotte
English, Leo V.....Detroit
Eno, Laurel S.....Detroit
Ensign, Dwight C.....Detroit
Ensing, Osborn.....Detroit
Epstein, S. G.....Detroit
Erickson, Eldon W.....Detroit
Erickson, Milton H.....Eloise
Erkfitz, Arthur W.....Detroit
Erman, Joseph M.....Detroit
Eschbach, Joseph W.....Dearborn
Estabrook, Bert U.....Detroit
Ettinger, Clayton J.....Detroit
Evans, Joseph M.....Detroit
Evans, Leland S.....Redford
Evans, William A., Jr.....Detroit
Ewing, C. H.....Grosse Pte. Village

Fagin, Irving D.....Detroit
Fagin, Joseph.....Detroit
Fair, Baxter B.....Detroit
Falick, M. L.....Detroit
Falk, Ira E.....Detroit
Fallis, Lawrence S.....Detroit
Fandrich, Theodore.....Detroit
Farbman, Aaron A.....Detroit
Farbman, Simon S.....Detroit
Fauman, David H.....Detroit
Faunce, Sherman P.....Detroit
Feeley, Marshall J.....Detroit
Felcyn, W. George.....Detroit
Feld, David.....Detroit
Feldkamp, Lee E.....Detroit
Feldman, Paul.....Detroit
Feldstein, Martin Z.....Detroit
Fellers, Ray L.....Detroit
Fenech, Harold B.....Detroit
Fenner, Wm. A.....Detroit
Fenner, Wm. G.....Detroit
Fenton, E. H.....Detroit
Fenton, Meryl M.....Detroit
Fenton, Russell F.....Detroit
Fenton, Stanley C.....Detroit
Ferrera, Louis V.....Detroit
Ferrara, Virginia M.....Detroit
Fettig, Carl A.....Grosse Pointe Park
Finch, Alvis D.....Detroit
Finch, F. Sinclair.....Detroit
Fine, Edward.....Detroit
Fischer, Frederick J.....St. Clair
Fisher, George S.....Detroit
Fisher, O. O.....Detroit
Fisher, R. L.....Detroit
Fitzgerald, James M.....Detroit
Fitz Porter, A. L.....Dearborn
Flaherty, H. J.....Detroit
Flaherty, N. W.....Detroit
Fleming, L. N.....Detroit
Flora, Wm. R.....Detroit
Flower, J. A.....Detroit
Fogt, Herbert E.....Detroit
Fogt, Robert G.....Detroit
Foley, Hugh S.....Dearborn

Foley, Joseph M.....Detroit
Font, Anthony J.....Detroit
Foote, James A.....Lincoln Park
Ford, George A.....Detroit
Ford, Sylvester.....Detroit
Ford, Walter D.....Detroit
Fordell, F. S.....Detroit
Forrester, Alex V.....Detroit
Forsythe, John R.....Detroit
Foster, E. Bruce.....Detroit
Foster, Daniel P.....Detroit
Foster, Linus J.....Detroit
Foster, Owen C.....Detroit
Foster, Wm. L.....Detroit
Foster, W. M.....Detroit
Fowler, Melvin E.....Detroit
Fox, Morris Edward.....Detroit
Fraiberg, Paul L.....Detroit
Franjac, M. J.....Dearborn
Franklin, James.....Detroit
Franklin, John.....Detroit
Franzen, Nils A.....Detroit
Fraser, Eldred E.....Detroit
Frazer, Mary Margert.....Detroit
Free, Harry W.....Detroit
Freedman, John.....Detroit
Freedman, Milton.....Detroit
Freeman, B. F.....Detroit
Freeman, D. K.....Detroit
Freeman, Mabel.....Detroit
Freeman, Michael.....Detroit
Freeman, Thelma.....Detroit
Freeman, Wilmer.....Detroit
Freese, John A.....Detroit
Freid, Samuel.....Detroit
Fremont, Joseph C.....Detroit
Freund, Hugo A.....Detroit
Fried, Bernard H.....Detroit
Friedlaender, Alex S.....Detroit
Friedlaender, Sidney.....Detroit
Friedman, David.....Detroit
Friedman, I. H.....Detroit
Frothingham, George E.....(E) Detroit
Fruend, Henrietta.....Detroit
Fulgenzi, Andrew A.....Detroit
Fullenwider, Allan C.....Detroit
Fuller, Hugh M.....Detroit
Fulton, Wm. James.....Detroit

Gaba, Howard.....Detroit
Gabe, Sigmund.....Los Angeles, Calif.
Gaberman, David B.....Detroit
Gaffney, J. Mitchell.....Detroit
Galantowicz, H. C.....Detroit
Galdonyi, Laslo L.....Detroit
Galdonyi, Nicholas.....Detroit
Galerneau, D. B.....Center Line
Galvin, Paul P.....Detroit
Gamble, Parker B.....Detroit
Gannan, Arthur M.....Detroit
Ganschow, John H.....Detroit
Gardner, Lawrence.....Detroit
Gariepy, Louis J.....Detroit
Garner, Howard B.....(E) Detroit
Gaston, Herbert B.....Detroit
Gates, Nathaniel H.....Detroit
Gaynor, Alex.....Detroit
Gehring, Harold W.....Detroit
Gehrke, August E.....Birmingham
Geib, Ledru O.....Detroit
Geib, Wayne A.....Grosse Pointe Park
Geiter, Clyde W.....Detroit
Geitz, Wm. A.....Detroit
Gelbach, Philip D.....Detroit
Gellert, I. S.....Detroit
Gemeroy, J. C.....Detroit
Gerondale, Edmond J.....Detroit
Gibson, James C.....(E) Detroit
Giese, Fred W.....Detroit
Gigante, Nicola.....Detroit
Gilbert, Harold R.....Wyandotte
Gillespie, Stephen M.....Dearborn
Gillman, R. W.....(E) Detroit
Gingold, Samuel M.....Detroit
Ginsberg, Harold I.....Detroit
Gitlin, Charles.....Detroit
Gitlin, Julius R.....Detroit
Gittins, Perry C.....Detroit
Glasgow, Gordon K.....Detroit
Glassman, Samuel.....Detroit
Glazer, Walter S.....Detroit
Gleason, John E.....Detroit
Glees, J. L.....Grosse Pointe Farms
Glement, Raymond B.....Detroit
Glowacki, B. F.....Detroit
Gmeiner, Clarence C.....Detroit
Goerke, Elmer A.....Romulus
Goetz, Angus G.....Detroit
Goins, Wm. F.....Detroit
Goldberg, Arthur.....Detroit
Goldberg, Harry H.....Detroit
Goldberg, Nathan.....Detroit
Goldin, M. I.....Eloise
Goldman, Aubrey.....Detroit
Goldsmith, Joseph D.....Detroit
Goldstone, R. R.....Detroit

Gollman, Maurice D. ....Detroit
Gonne, Wm. S. ....Detroit
Goodrich, B. E. ....Detroit
Gordon, John W. ....(R) Detroit
Gordon, William H. ....Detroit
Gorelick, Martin J. ....Dearborn
Gorning, Raymond P. ....Detroit
Goryl, Stephen V. ....Detroit
Goss, Samuel B. ....Detroit
Gottschalk, Fred W. ....Detroit
Gould, S. E. ....Eloise
Gourley, E. V. ....Detroit
Goux, Louise J. ....Detroit
Goux, R. S. ....Detroit
Grace, J. M. ....Detroit
Graff, J. M. ....Detroit
Graham, Julius A. ....Detroit
Grain, Gerald O. ....Detroit
Grajewski, Leo E. ....Detroit
Gramley, Wm. ....Detroit
Granger, Francis L. ....Detroit
Gratton, Henri L. ....Detroit
Gravelle, Lawrence J. ....Detroit
Green, Ellis R. ....Detroit
Green, Lewis ....Detroit
Green, Louis M. ....Detroit
Green, Nelson W. ....Pleasant Ridge
Green, Simpson W. ....Detroit
Greenberg, Jack R. ....Detroit
Greenberg, Julius J. ....Detroit
Greenberg, Morris Z. ....Detroit
Greene, John B. ....Detroit
Greenidge, Robert ....Detroit
Greenlee, Wm. Tate ....Detroit
Greiner, Bert A. ....Detroit
Grekin, John N. ....Detroit
Grekin, Samuel L. ....Detroit
Griffith, Arthur J. ....Detroit
Grillo, S. Phillip ....Belleville
Grimaldi, G. J. ....Detroit
Grinstein, Alexander ....Detroit
Grob, Otto ....Detroit
Grossman, Sol. ....Detroit
Gruber, T. K. ....Eloise
Guimaraes, A. S. ....Dearborn
Gurdjian, E. S. ....Detroit
Gutow, Benjamin R. ....Detroit

Haefele, Leslie P. ....Garden City
Haking, Leonard ....Detroit
Hale, Arthur S. ....Detroit
Hall, Archie C. ....Detroit
Hall, E. Walter ....Detroit
Hall, James A. J. ....Detroit
Hall, Ralph E. ....Detroit
Hall, Robert J. ....Detroit
Haluska, Joseph A. ....Detroit
H'Amada, Norman K. ....Detroit
Hamburger, A. C. ....Detroit
Hamil, Brenton M. ....Detroit
Hamilton, Norman C. ....Detroit
Hamilton, William ....Detroit
Hamilton, Wm. F. ....(L) Detroit
Hammer, Edwin J. ....Detroit
Hammer, Howard J. San Francisco, Cal.
Hammond, A. E. ....Detroit
Hammond, James L. ....Inkster
Hand, Fordus V. ....Detroit
Hanna, E. Howard ....Detroit
Hansen, Frederick E. ....Detroit
Hanser, Joshua ....(L) Detroit
Hanson, Frederick N. ....Wayne
Hanson, Joseph ....Detroit
Harelik, E. W. ....Detroit
Hardstaff, R. John ....Detroit
Hardy, George C. ....Detroit
Harley, Garth H. ....Detroit
Harley, Louis M. ....Detroit
Harm, W. B. ....Detroit
Harper, Jesse T. ....Detroit
Harrell, Voss ....Detroit
Harris, Harold H. ....Detroit
Harris, Ivor D. ....Detroit
Harrison, Hugh ....(E) Detroit
Harrison, Wesley ....Detroit
Hart, Charles E. ....Detroit
Hart, J. Clarence ....Detroit
Hartmann, W. B. ....Detroit
Hartzell, John B. ....Detroit
Hasley, Clyde K. ....Detroit
Hasley, Daniel E. ....Detroit
Hassig, Walter W. ....Detroit
Hastings, Orville J. ....Detroit
Hause, Glen E. ....Detroit
Hauser, T. Jerome ....Detroit
Hauser, John E. ....Detroit
Hauser, Maurice ....Detroit
Havers, Howard ....Detroit
Hawkins, James W. ....Detroit
Hayes, Joseph D. ....Detroit
Heath, Leonard P. ....Detroit
Heath, Parker ....Bloomfield Hills
Heavner, L. E. ....Detroit
Hecht, Manes ....Detroit
Hedgeman, E. C. ....Detroit
Hedges, Frank W. ....Detroit

Hedrick, Donald W. ....Detroit
Heenan, T. H. ....Detroit
Heideman, Louis ....Detroit
Heldt, Thomas J. ....Detroit
Hendelman, Manuel H. ....Detroit
Henderson, A. B. ....Detroit
Henderson, Harold ....Detroit
Henderson, Leslie T. ....Detroit
Henderson, Wm. E. ....Detroit
Henig, Fred ....Detroit
Henrich, L. E. ....Detroit
Herkimer, Dan R. ....Lincoln Park
Herrold, Rose E. ....Detroit
Herschelmann, Roy F. ....Detroit
Hershey, Lynn N. ....Birmingham
Hewitt, Leland V. ....Detroit
Hewitt, Robert S. ....Dearborn
Heyner, Stanley A. ....Detroit
Hickey, Joseph ....Detroit
Hicks, Fred G. ....Dearborn
Hiebert, J. M. ....Detroit
Higbee, Arthur L. ....Detroit
Hileman, Lee ....Ecorse
Hillenbrand, Alfred E. ....Grosse Pointe
Hillenbrand, Carl M. ....Detroit
Hiller, Glenn I. ....Detroit
Hilton, Wm. E. ....Detroit
Hinko, Edward N. ....Eloise
Hirschfield, Alexander H. ....Detroit
Hirschman, L. J. ....Detroit
Hochman, Morton M. ....Detroit
Hodgkinson, C. P. ....Detroit
Hodoski, Frank J. ....Detroit
Hoenig, Andrew L. ....Mancelona
Hoffman, E. S. ....Detroit
Hoffman, Edward A. ....Detroit
Hoffman, Harry Y. ....Detroit
Hoffman, Henry A. ....Detroit
Hoffmann, Martin H. ....Detroit
Holcomb, August A. ....Northville
Holcomb, Clayton E. ....Detroit
Hollander, A. J. ....Detroit
Hollis, Henry B. ....Detroit
Holloway, Horace R. ....Detroit
Holman, Herbert H. ....Detroit
Holmes, Alfred W. ....Detroit
Holt, Henry T. ....Detroit
Honhart, Fred L. ....Detroit
Honor, Wm. H. ....Wyandotte
Hookey, J. A. ....Wyandotte
Hooper, Norman L. ....Detroit
Hoops, George B. ....Detroit
Hopkins, J. E. ....Detroit
Horan, Thomas ....Detroit
Horkins, Harold A. ....Detroit
Horny, Hugo ....Detroit
Horton, Reece H. ....Detroit
Horvath, Louis O. ....Detroit
Horwitz, John B. ....Detroit
Hotchkiss, Loris M. ....Farmington
Howard, Austin Z. ....Detroit
Howard, Phillip J. ....Detroit
Howell, Bert F. ....Detroit
Howes, Homer Allen ....Detroit
Howes, Willard Boyden ....Detroit
Howlett, Howard T. ....Detroit
Hromadko, Louis ....Detroit
Hubbard, John P. ....Detroit
Hubbard, Ralph G. ....Detroit
Hudson, J. Stewart ....Grosse Pointe
Hudson, Wm. A. ....Detroit
Huegli, Wilfred A. ....Detroit
Huff, Reginald G. ....Wayne
Hughes, Alberti A. ....(L) Detroit
Hull, L. W. ....Detroit
Hunt, T. H. ....Detroit
Hunt, Verne G. ....Detroit
Hunter, Basil H. ....Detroit
Hunter, Elmer N. ....Detroit
Husband, Charles W. ....Detroit
Hussey, Raymond ....Detroit
Hyatt, Jarvis M. ....Dearborn
Hyde, Frederick W. ....Detroit
Hyman, S. J. ....Inkster

Iacobell, Peter H. ....Detroit
Igna, Eli J. ....Detroit
Ignatius, A. A. ....Detroit
Ihle, Lyman E. ....Chippewa Falls, Wis.
Insley, Stanley W. ....Detroit
Irvin, Earle Albert ....Detroit
Irwin, W. A. ....Detroit
Israel, Barney B. ....Detroit
Israel, J. G. ....Detroit
Iwata, Herbert ....Detroit

Jackson, George F. ....Detroit
Jacobson, Samuel D. ....Detroit
Jacoby, Myron D. ....Detroit
Jaeger, Grove A. ....Detroit
Jaeger, Juilius P. ....(L) Detroit
Jaekel, C. N. ....Detroit
Jaffar, Donald J. ....Detroit
Jaffe, I. L. ....Detroit
Jaffe, Jacob ....Detroit
Jaffe, Louis ....Detroit
Jahsman, William E. ....Detroit

James, Richard G. ....Detroit
Jamieson, Thomas J. ....Lincoln Park
Janicki, Natalia J. ....Eloise
Jarre, Hans A. ....Detroit
Jarvis, Harold ....Detroit
Jarzembowski, F. B. ....Detroit
Jarzynka, Frank J. ....Dearborn
Jasion, Lawrence J. ....Detroit
Jend, Wm. ....(L) Detroit
Jenkins, E. A. ....Detroit
Jenne, Byron H. ....Detroit
Jennings, Robert M. ....Dearborn
Jentgen, Charles J. ....Detroit
Jentgen, L. G. ....Detroit
Jenton, O. Henry ....Detroit
Jeremias, Robert C. ....Detroit
Jewell, F. C. ....Detroit
Jocz, M. W. ....Grosse Pointe Park
Jodar, E. O. ....Detroit
John, Hubert R. ....Detroit
Johnson, Homer L. ....Detroit
Johnson, Ralph A. ....Detroit
Johnson, Vernon P. ....Detroit
Johnson, Vincent C. ....Detroit
Johnson, W. H. M. ....Detroit
Johnston, Charles G. ....Detroit
Johnston, Everett V. ....Detroit
Johnston, J. A. ....Detroit
Johnston, John L. ....Detroit
Johnston, Wm. E. ....Detroit
Johnstone, Benjamin I. ....Detroit
Joinville, E. V. ....Detroit
Jones, Adrian R. ....Detroit
Jones, Arthur J. ....Detroit
Jones, Edna M. ....Northville
Jones, L. Faunt ....Detroit
Jones, Roy D. ....Detroit
Jordan, R. Gerald ....Detroit
Joyce, Stanley J. ....Detroit
Juliar, Benjamin ....Detroit
Jurow, Harry N. ....Detroit

Kalayjian, Bernard S. ....Detroit
Kallet, Herbert I. ....Detroit
Kallman, David ....Detroit
Kallman, Leo ....Detroit
Kallman, R. Robert ....Detroit
Kaminski, Zeno L. ....Detroit
Kamperman, George A. ....Detroit
Kanter, Herman ....Detroit
Kapetansky, A. J. ....Detroit
Kapetansky, Nathan J. ....Detroit
Kaplita, Walter A. ....Hamtramck
Karr, Herbert S. ....Detroit
Kasabach, Harry Y. ....Detroit
Kasaback, V. Y. ....Detroit
Kasper, Joseph A. ....Detroit
Kass, Arnold ....Detroit
Kass, J. B. ....Detroit
Kates, Simon C. ....Detroit
Katzman, I. S. ....Detroit
Kaump, Donald H. ....Detroit
Kauppinen, J. A. ....Detroit
Kay, Edward W. ....Hamtramck
Kazdan, Louis ....Detroit
Kazdan, Morris A. ....Allen Park
Keane, Wm. E. ....Allen Park
Keating, Thomas F. ....Detroit
Kehoe, Henry J. ....East Detroit
Keim, H. L. ....Detroit
Kelmenson, V. A. ....Detroit
Kelson, Malcolm J. ....Detroit
Kemler, Walter J. ....Escore
Kemp, Hardy A. ....Detroit
Kennary, James M. ....Detroit
Kennedy, Charles S. ....Detroit
Kennedy, Donald J. ....Detroit
Kennedy, Lester F. ....Detroit
Kennedy, Robert B. ....Detroit
Kern, W. H. ....Garden City
Kernkamp, Ralph ....Detroit
Kernick, M. O. ....Detroit
Kersten, Armand G. ....Detroit
Kersten, Werner ....Detroit
Kerzman, Joseph H. ....Detroit
Keshishian, Sarkis K. ....Detroit
Keyes, Eugene Charles ....Dearborn
Keyes, John W. ....Detroit
Kibzey, Ambrose T. ....Sault Ste. Marie
Kidner, Frederick C. ....Detroit
Kimberlin, Kenneth K. ....Detroit
King, Edward D. ....Detroit
King, Melbourne J. ....Detroit
Kingswood, Roy C. ....Detroit
Kinsley, George ....Detroit
Kirchner, Augustus ....Detroit
Kirker, J. G. ....Detroit
Kirschbaum, Harry M. ....Detroit
Klebba, Paul ....Detroit
Klein, William ....Detroit
Kleinman, S. ....Detroit
Kliger, David ....Detroit
Kline, Lewis Le Roy ....Detroit
Kline, Starr L. ....Detroit
Klosowski, Joseph ....Detroit
Klote, M. D. ....Detroit

Knaggs, Charles W. ... Grosse Pointe
Knaggs, Earl J. ... Wyandotte
Knapp, Byron S. ... River Rogue
Knapp, Floyd ... Detroit
Knobloch, Edmund J. ... Detroit
Knoch, Hubert S. ... Detroit
Knox, Ross M. ... Escorse
Koebel, R. H. ... Detroit
Koerber, Edward J. ... Detroit
Koessler, George L. ... Detroit
Kohn, M. E. ... Detroit
Kokowicz, Raymond J. ... Detroit
Kolasa, W. B. ... Detroit
Kopel, Joseph O. ... Detroit
Korby, George J. ... Detroit
Koren, Louis ... Eloise
Kossayda, Adam W. ... Detroit
Koster, Koert ... Detroit
Kovacb, Emery P. ... Detroit
Kovan, D. D. ... Detroit
Koven, Abrabam ... Detroit
Kozlinski, Anthony E. ... Detroit
Kozlow, Louise E. ... Detroit
Kraft, Raymond B. ... Detroit
Kraft, Ruth M. ... Detroit
Krass, Edward W. ... Detroit
Kraus, John J. ... Detroit
Krebs, William T. ... Detroit
Kreinbring, George E. ... Detroit
Kretzschmar, Clarence A. ... Detroit
Kretzschmar, John C. ... Detroit
Krieg, Earl G. ... Detroit
Krieger, Harley L. ... Detroit
Kritchman, M. J. ... Detroit
Kroha, Lawrence ... Detroit
Krohn, Albert H. ... Detroit
Krynicki, Francis X. ... Detroit
Kubanek, Joseph L. ... Dearborn
Kucmierz, Francis S. ... Detroit
Kuhn, Albert A. ... Detroit
Kuhn, Richard F. ... Detroit
Kulaski, Chester H. ... Detroit
Kullman, Harold J. ... Dearborn
Kurcz, J. A. ... Detroit
Kurtz, I. J. ... Detroit
Kwasiborski, S. A. ... Wyandotte

LaBerge, James M. ... Wyandotte
La Bine, Alfred C. ... Detroit
La Core, Ivan ... Detroit
La Ferte, Alfred D. ... Detroit
Lakoff, Charles ... Detroit
Lam, Conrad R. ... Detroit
Lamberson, Frank A. ... Detroit
La Marche, Norman O. ... Detroit
Lammy, James V. ... Detroit
Lampman, H. H. ... Detroit
Landers, M. B., Sr. ... Detroit
Landers, M. B., Jr. ... Detroit
Lang, Ernst Frederick ... Detroit
Lang, Leonard W. ... Detroit
Lange, Anthony H. ... Detroit
Laning, George M. ... Detroit
Lansky, Mandell ... Detroit
Lapham, Fred E. ... Detroit
Larsson, Bror H. ... Detroit
Lasley, James W. ... Detroit
Lassaline, S. J. ... Detroit
Lathrop, Philip L. ... Detroit
Latteier, K. K. ... Detroit
Laub, Stanley V. ... Detroit
Lauppe, Edward H. ... Detroit
Lauppe, F. A. ... Detroit
Laurisin, Eugene ... Detroit
Lazar, Morton R. ... Detroit
Leach, David ... Detroit
Leacock, Robert C. ... Detroit
Leader, L. R. ... Detroit
Leaver, L. Ross ... Detroit
Leckie, George C. ... Detroit
Ledwidge, Patrick L. ... Detroit
Lee, Harry E. ... Detroit
Le Gallee, George M. ... Detroit
Leibinger, Henry R. ... Detroit
Leipsitz, Louis S. ... Detroit
Leiser, Rudolf ... Eloise
Leithauser, D. J. ... Detroit
Leland, Sol ... Detroit
Lemley, Clark ... Detroit
Lemmon, Charles E. ... Detroit
Lemmon, Clarence W. ... River Rouge
Lentine, James J. ... Detroit
Lenz, Willard R. ... Detroit
Lepard, C. W. ... Detroit
Leppley, Fred O. ... Detroit
Lerman, S. E. ... Van Dyke
Lescoheir, Alex W. ... Grosse Pointe
L'Esperance, Simon P. ... Detroit
Leszynski, J. S. ... Detroit
Leucutia, Traian ... Detroit
Levant, Arthur B. ... Detroit
Levin, David M. ... Detroit
Levin, Michael ... Detroit
Levin, Samuel J. ... Detroit
Lewine, Edward E. ... Detroit
Levine, Sidney S. ... Detroit

Levitt, Edward J. ... Detroit
Levitt, Nathan ... Detroit
Levy, Marvin B. ... Detroit
Lewis, Charles T. ... Detroit
Lewis, J. Hugb ... Wyandotte
Lewis, L. A. ... Detroit
Libbrecht, Robert V. ... Dearborn
Lichtwardt, Hartman A. ... Detroit
Liddicoat, A. G. ... Detroit
Lieberman, B. L. ... Detroit
Lightbody, James J. ... Detroit
Lignell, Rudolph ... Detroit
Lilly, Charles J. ... Detroit
Linn, Frank D. ... Detroit
Linton, James R. ... Eloise
Lipinski, Stanley L. ... Detroit
Lipkin, Ezra ... Detroit
Lippold, Paul H. ... Detroit
Lipton, Raymond ... Detroit
Lipshutz, Louis ... Eloise
Littlejobn, David ... Eloise
Livingston, George D. ... Detroit
Livingston, George M. ... (R) Detroit
Llewellyn, M. B. ... Detroit
Lockwood, Bruce C. ... Detroit
Lofstrom, James E. ... Detroit
Long, Earle C. ... Detroit
Long, Jobn J. ... Detroit
Longyear, Harold W. ... Detroit
Lookanoff, Victor A. ... Detroit
Loranger, C. B. ... Detroit
Lorber, Joseph H. ... Detroit
Lorentzen, Edwin H. ... Detroit
Lovas, W. S. ... Detroit
Love, W. Thomas ... Detroit
Lovell, B. K. ... Detroit
Lowe, Adolf ... Detroit
Lowe, Townsend ... Detroit
Lowrie, G. B. ... (L) Grosse Pointe
Lowrie, Wm. L., Jr. ... Detroit
Lowry, George L. ... Detroit
Luce, Henry A. ... Detroit
Lukas, John R. ... Detroit
Lum, Thomas K. ... Williams Field Ariz.
Lutz, Earl F. ... Detroit
Lynn, David H. ... Detroit
Lynn, Harvey D. ... Detroit
Lyons, L. Mason ... Detroit
Lyons, Wm. Harrington ... Detroit
Lytle, Robert P. ... Detroit

Mabee, Frank P. ... Detroit
Mabley, J. Donald ... Detroit
MacArthur, Robert A. ... Detroit
MacCracken, Frances L. ... Detroit
MacDougall, Orrin P. ... Detroit
MacFarlane, Howard W. ... Detroit
MacGregor, W. W. ... Detroit
Mack, Harold C. ... Detroit
MacKenzie, Earle D. ... Detroit
MacKenzie, Edward P. ... Detroit
MacKenzie, Frank M. ... Detroit
Mackenzie, John W. ... Grosse Pointe
Mackersie, W. G. ... Detroit
MacMillan, Francis B. ... Detroit
MacMullen, Frank B. ... Detroit
MacQueen, Malcolm D. ... Detroit
MacPherson, K. C. ... Detroit
Maczewski, John E. ... Detroit
Madsen, Martha ... Detroit
Magnell, Ralph C. ... Detroit
Maguire, Clarence E. ... Detroit
Mahoney, Hugh M. ... Detroit
Maibauer, F. P. ... Wyandotte
Maino, L. J. ... Detroit
Mains, M. Paul ... Detroit
Maire, E. D. ... Grosse Pointe
Mair, Harold U. ... Detroit
Malachowski, B. T. ... Detroit
Malik, Edward A. ... Detroit
Malik, Nur M. ... Detroit
Malina, Stephen ... Detroit
Maloney, John A. ... Detroit
Mancuso, Vincent ... Detroit
Mandiberg, Jack N. ... Detroit
Manning, Morey H. ... Detroit
Maples, Douglas E. ... Detroit
Marcotte, Oliver ... Detroit
Marcus, Daniel B. ... Detroit
Marinus, Carleton J. ... Detroit
Mark, Jerome ... Detroit
Markoe, Rupert C. L. ... Detroit
Marks, Ben ... Detroit
Marks, Morris ... Detroit
Marsden, Thomas B. ... Detroit
Marsh, Alton R. ... Detroit
Marshall, James R. ... Detroit
Marshall, Millard R. ... Detroit
Martin, Edward G. ... Detroit
Martin, Elbert A. ... Detroit
Martin, I. Herbert ... Detroit
Martin, J. B., Jr. ... Detroit
Martin, L. R. ... Detroit
Martin, Peter A. ... Detroit
Martin, R. M. ... Detroit
Martin, Richard D. ... Detroit

Martin, Wilbur C. ... Detroit
Martinez, P. O. ... Detroit
Martmer, Edgar ... Detroit
Marwil, T. B. ... Detroit
Mason, Percy W. ... Detroit
Mateer, John G. ... Detroit
Mathes, Charles J. ... Detroit
Matthews, Wallace ... Detroit
Maun, Mark E. ... Detroit
Maxwell, J. Harvey ... Detroit
May, Frederick T., Jr., ... Detroit
Mayer, E. V. ... Detroit
Mayer, Willard D. ... Detroit
Maynard, Fred M. ... Allen Park
Mayne, Cecil H. ... Detroit
McAfee, F. W. ... Detroit
McAlonan, Wm. T. ... Detroit
McAlpine, Archibald D. ... Detroit
McAlpine, Gordon S. ... Detroit
McBroom, Russell E. ... Detroit
McClellan, Robert J. ... Detroit
McClendon, James J. ... Detroit
McClintock, J. J. ... Detroit
McClure, Robert W. ... Detroit
McClure, Roy D. ... Detroit
McClure, Wm. R. ... Detroit
McColl, Charles W. ... Wyandotte
McColl, Clarke M. ... Detroit
McColl, Kenneth M. ... Detroit
McCollum, E. B. ... Detroit
McCord, Carey P. ... Detroit
McCormick, Colin C. ... Dearborn
McCormick, C. W. ... Detroit
McCullough, Lester E. ... Detroit
McDonald, Angus L. ... Detroit
McDonald, George O. ... Detroit
McDonald, Grant ... Highland Park
McDonald, Peter W. ... Wyandotte
McDougall, B. Wm. ... Detroit
McEvitt, Wm. G. ... Detroit
McFadyen, Hugh A. ... Detroit
McGarvah, A. W. ... Detroit
McGarvah, Joseph A. ... Detroit
McGhee, Richard S. ... Detroit
McGillicuddy, Walter E. ... Detroit
McGinnis, Daniel H. ... Detroit
McGlaughlin, Nicholas D. ... Wyandotte
McGough, Joseph M. ... Detroit
McGrath, Neil B., Jr. ... Detroit
McGraw, Arthur B. ... Detroit
McGuire, Ivan A. ... Detroit
McGuire, M. Ruth ... Detroit
McIntosh, W. V. ... Detroit
McIntyre, Wm. D. ... Detroit
McKean, G. Thomas ... Detroit
McKean, Richard M. ... Detroit
McKenna, Charles J. ... Detroit
McKinley, Donald ... Detroit
McKinnon, John D. ... Detroit
McLane, Harriett E. ... Detroit
McLean, Don W. ... Detroit
McLean, Harold G. ... Detroit
McPherson, E. Glenn ... Dearborn
McPherson, R. J. ... Detroit
McQuiggan, Mark R. ... Detroit
McRae, Donald H. ... Detroit
Mead, John ... Detroit
Meinecke, H. A. ... Detroit
Mellen, Hyman S. ... Detroit
Melnik, Maxim P. ... Detroit
Menagh, Frank R. ... Detroit
Mendelssohn, R. J. ... Detroit
Merkel, Charles C. ... Grosse Pointe
Merrill, Wm. O. ... Detroit
Merriman, K. S. ... Detroit
Merritt, Earl G. ... Detroit
Metzger, Harry C. ... Detroit
Meyer, Ruben ... Detroit
Meyers, M. P. ... Detroit
Meyers, Solomon G. ... Detroit
Miley, H. H. ... Detroit
Millard, Glenn E. ... Detroit
Miller, Daniel H. ... Detroit
Miller, Elmer B. ... Detroit
Miller, Hazen L. ... Detroit
Miller, Karl ... Detroit
Miller, M. M. ... Detroit
Miller, Maurice P. ... Trenton
Miller, Myron H. ... Detroit
Miller, T. H. ... Detroit
Miller, Wm. E. ... Detroit
Mills, Clinton C. ... Detroit
Mills, Georgia V. ... Detroit
Milton, Boynton A. ... Inkster
Mintz, Morris J. ... Detroit
Mintz, Edward I. ... Detroit
Miral, Solomon P. ... Detroit
Miro, Morey D. ... Detroit
Mishelevich, Sophie ... Detroit
Mitchell, C. Leslie ... Detroit
Mitchell, Gertrude F. ... Detroit
Mitchell, Ralston S. ... Detroit
Mitchell, W. Bede ... Detroit
Moehlig, Robert C. ... Detroit
Moisides, V. P. ... Detroit

Moll, Clarence D. ... Detroit
Molner, Joseph G ... Detroit
Molner, Stephen ... Detroit
Moloney, J. Clark ... Birmingham
Mond, Edward ... Detroit
Monfort, Willard ... (L) Highland Park
Montgomery, John C. ... Detroit
Montante, Joseph R. ... Detroit
Moore, James A. ... Detroit
Morand, Louis J. ... Detroit
Moriarty, George ... Detroit
Morin, John B. ... Detroit
Moritz, H. C. ... Detroit
Morley, Harold V. ... Detroit
Morley, James A. ... Detroit
Moroun, S. J. ... Detroit
Morris, Harold L. ... Detroit
Morris, Roger S. ... Grosse Pointe
Morrison, Marjorie G. E. ... Detroit
Morse, Plinn F. ... Detroit
Morton, David G. ... Detroit
Morton, J. B. ... (L) Detroit
Mosee, W. Jones ... Detroit
Mosen, Max M. ... Detroit
Moss, E. B. ... Detroit
Moss, Nathan H. ... Detroit
Moss, Selma S. ... Detroit
Mott, Carlin P. ... Detroit
Moulton, Charles ... Detroit
Muellenhagen, Walter J. ... Detroit
Munson, F. T. ... Detroit
Munson, Henry T. ... Detroit
Muntyan, Andrew ... Detroit
Murphy, D. J. ... Detroit
Murphy, Frank J. ... Detroit
Murphy, John M. ... Detroit
Murphy, Scipio G. ... Detroit
Murphy, W. M. ... Detroit
Murphy, Robert T. ... Detroit
Murray, George M. ... Detroit
Murray, William A. ... Detroit
Muske, Paul H. ... Detroit
Myers, Dan W. ... Detroit
Myers, Gordon B. ... Grosse Pointe

Nagel, Oscar ... Detroit
Nagle, John W. ... Wyandotte
Nahigian, Russell ... Dearborn
Naud, Henry J. ... Detroit
Nawotka, E. E. ... Detroit
Naylor, A. E. ... Detroit
Naylor, Arthur H. ... Detroit
Neeb, Walter G. ... Detroit
Nelson, Harry M. ... Detroit
Nelson, Victor E. ... Detroit
Nettleship, Anderson ... Detroit
Neumann, Arthur J. ... Detroit
Newbarr, Arthur A. ... Detroit
Newman, Max Karl ... Detroit
Nielsen, Aage E. ... Detroit
Nichamin, Samuel J. ... Detroit
Nickerson, Dean ... Highland Park
Nigro, Norman D. ... Detroit
Nill, John B. ... Detroit
Nill, Wm. F. ... Detroit
Noble, Wm. C. ... Ecorse
Noer, Rudolf J. ... Grosse Pointe Farms
Nolan, Bernard E. ... Detroit
Nolting, Wilfred S. ... Detroit
Norconk, A. A. ... Detroit
Norris, Edgar H. ... Detroit
Northrop, Arthur K. ... (E) Detroit
Northrop, Arthur, Jr. ... Detroit
Norton, A. B. ... Detroit
Norton, Charles S. ... Detroit
Noth, Paul H. ... Grosse Pointe Farms
Novy, R. L. ... Detroit
Nowicki, Joseph A. ... Detroit

O'Brien, E. J. ... Detroit
O'Brien, G. M. ... Detroit
O'Donnell, Charles ... Dearborn
O'Donnell, David H. ... (E) Detroit
O'Donnell, Dayton H. ... Detroit
Ohmart, Galen B. ... Detroit
O'Hora, James T. ... Detroit
Ohrt, Harold F. ... Detroit
Okun, Milton H. ... Detroit
Olechowski, Leo W. ... Bremerton, Wash.
Olen, Alex ... Detroit
O'Linn, Francis P. ... Detroit
Olmsted, Wm. R. ... Detroit
Oman, Cyrus F. ... Detroit
Oppenheim, J. M. ... Detroit
Orecklin, L. ... Detroit
Organ, Fred W. ... Detroit
Ormond, John K. ... Detroit
Ornstein, Charles ... Detroit
O'Rourke, Paul V. ... Detroit
O'Rourke, R. M. ... Detroit
Osius, Eugene A. ... Detroit
Ott, Harold A. ... Detroit
Ottaway, John P. ... Detroit
Owen, Clarence I. ... Detroit
Owen, James A. ... Detroit
Owens, Betty B. ... Detroit
Palmer, Alice ... Detroit

Palmer, Hayden ... Detroit
Pangburn, L. E. ... Detroit
Panic, Stephen M. ... Detroit
Panzer, Edward J. ... (E) Detroit
Parker, Benjamin R. ... Detroit
Parker, Walter R. ... (E) Detroit
Parkinson, Dorris ... Detroit
Parr, R. W. ... Detroit
Parsons, John P. ... Grosse Pointe Park
Pasternacki, Norbert T. ... Detroit
Paterson, Walter G. ... (L) Detroit
Pawlowski, Jerome ... Detroit
Payne, Eugene ... Detroit
Paysner, Harry A. ... Detroit
Peabody, Charles W. ... Detroit
Peacock, Lee W. ... Highland Park
Pearman, Chas. L. R. ... Detroit
Pearse, Harry A. ... Detroit
Peggs, George F. ... Detroit
Penberthy, Grover C. ... Detroit
Pendy, John M. ... Detroit
Pensler, Meyer ... Detroit
Pequegnot, Charles F. ... (L) Detroit
Perdue, Grace M. ... Detroit
Perkin, Frank S. ... Detroit
Perkins, Ralph A. ... Detroit
Perlis, H. L. ... Detroit
Perry, Alvin, La Forge ... Detroit
Peterman, Earl A. ... Detroit
Petix, Samuel C. ... Detroit
Pevin, Pauline ... Detroit
Pfeffer, Isadore S. ... Detroit
Pfeiffer, Rudolph L. ... Detroit
Pheteplace, W. S. ... Detroit
Pichette, J. Walton ... Detroit
Pickard, Orlando W. ... Detroit
Pidgeon, Susan ... Detroit
Pierce, Frank L. ... Detroit
Pierson, Max J. ... Detroit
Pietraszewski, A. W. ... Detroit
Pilling, M. A. ... Detroit
Pinckard, Karl G. ... Dearborn
Pinney, Lyman J. ... Detroit
Pino, Ralph H. ... Detroit
Piper, Clark C. ... Detroit
Piper, Ralph R. ... Detroit
Pittman, J. E. ... Detroit
Plaggemeyer, H. W. ... Detroit
Pliskow, Harold ... Detroit
Podezwa, John W. ... Grosse Pointe Woods
Poirier, Ralph A. ... Detroit
Pollack, John J. ... Detroit
Pool, Walter D. ... Detroit
Poos, Edgar ... Detroit
Poretta, Anthony C. ... Detroit
Poretta, F. S. ... Detroit
Porter, Howard J. ... Romulus
Posner, Irving ... Detroit
Pratt, Jean P. ... Detroit
Pratt, Lawrence ... Detroit
Prendergast, John J. ... Detroit
Priborsky, Benjamin H. ... Detroit
Price, A. H. ... Detroit
Price, Alvin E. ... Detroit
Proctor, Bruce ... Detroit
Proud, Robert H. ... Flat Rock
Pugliesi, Benedetto ... Detroit
Purcell, Frank H. ... Detroit
Putra, A. M. ... Detroit

Quigley, William ... Detroit

Rabinovitch, Bella ... Detroit
Rahm, Lambert P. ... Detroit
Raiford, Frank P. ... Detroit
Raiford, Frank P., Jr. ... Detroit
Rao, John O. ... Detroit
Raskin, John ... Detroit
Raskin, Morris ... Detroit
Rastello, Peter B. ... Detroit
Ratigan, C. S. ... Dearborn
Raynor, Harold F. ... Detroit
Reberdy, George J. ... Detroit
Reder, Ben ... Detroit
Redfern, Wm. Earl ... Detroit
Reed, E. Hobart ... (A) Detroit
Reed, Everett H. ... Detroit
Reed, H. Walter ... Detroit
Rees, Howard C. ... Detroit
Reed, Ivor E. ... Detroit
Reichling, R. J. ... Detroit
Reid, J. Gilbert ... Detroit
Reid, Wesley G. ... Detroit
Reiff, Morris V. ... Detroit
Reinbolt, Charles A. ... (L) Detroit
Reinsh, Ernest R. ... Detroit
Reisman, Nathan J. ... Detroit
Rekshaw, W. R. ... Detroit
Renaud, G. L. ... (E) Detroit
Rennell, Leo P. ... Detroit
Renz, Russell H. ... Detroit
Reske, Alven ... Dearborn
Reveno, Wm. S. ... Detroit
Rexford, W. K. ... Detroit
Reye, H. A. ... Detroit
Reyner, C. E. ... Detroit
Reynolds, Lawrence ... Detroit

Reynolds, R. P. ... Detroit
Rezanka, Harold J. ... Grosse Pointe
Rhoades, F. P. ... Detroit
Rice, Harold B. ... Detroit
Rice, Meshel ... Oxford
Richardson, Allan L. ... Detroit
Richardson, Robert P. ... Wayne
Rick, Paul J. ... Detroit
Ridge, Ralph W. ... Wyandotte
Rieden, James A. ... Detroit
Rieckhoff, George G. ... Detroit
Rieg, John F. ... Detroit
Rieger, John B. ... Detroit
Rieger, Mary H. ... Detroit
Riseborough, E. C. ... Detroit
Rizzo, Frank ... Grosse Pointe Park
Rizzo, Paul ... Detroit
Robb, Ed. L. ... Detroit
Robb, Herbert F. ... Detroit
Robb, J. Milton ... Grosse Pointe Village
Roberts, Arthur J. ... Ecorse
Robins, Samuel C. ... Detroit
Robinson, Edwin L. ... Detroit
Robinson, Fred L. ... Dearborn
Robinson, George W. ... Detroit
Robinson, Harold A. ... Detroit
Robinson, Howard ... Detroit
Robinson, R. G. ... Detroit
Rogers, Aaron Z. ... Grosse Pointe Woods
Rogers, James D. ... Wyandotte
Rogin, James R. ... Detroit
Rogoff, A. S. ... Detroit
Rohde, Paul C. ... Detroit
Roland, Charles F. ... Detroit
Rom, Jack ... Detroit
Roman, Stanley J. ... Detroit
Roney, Eugene H. ... Detroit
Rosbolt, Oscar P. ... Detroit
Rose, Bernard ... Detroit
Rosefield, John L. ... Detroit
Rosen, Harold M. ... Detroit
Rosen, Robert ... Detroit
Roseman, J. D. ... Detroit
Rosenthal, Louis H. ... Detroit
Rosenthal, Samuel ... Detroit
Rosenzweig, Saul ... Detroit
Ross, Ben C. ... Detroit
Ross, D. G. ... Grosse Pointe
Ross, Hyman ... Dearborn
Rotarius, E. M. ... Detroit
Roth, Edward T. ... Detroit
Roth, Theodore I. ... Detroit
Rotbbart, H. B. ... Detroit
Rothman, Emil D. ... Detroit
Rothman, H. R. ... Detroit
Rottenberg, Leon ... Detroit
Rowda, Michael S. ... Detroit
Rowe, Robert ... Detroit
Rowell, Robert C. ... Eloise
Rucker, Julian J. ... Detroit
Rueger, Milton J. ... Detroit
Rueger, Ralph C. ... Detroit
Runge, Edward F. ... Detroit
Rupp, Robert H. ... Ferndale
Rupprecht, Emil F. ... Detroit
Ruskin, I. W. ... Detroit
Ruskin, Samuel H. ... Detroit
Russell, John C. ... Detroit
Rutzen, Arthur C. ... Detroit
Ryan, Charles F. ... Detroit
Ryan, W. D. ... Detroit
Rydzewski, Joseph B. ... Detroit
Ryerson, Frank L. ... Detroit

Sack, A. G. ... Detroit
Sa'Di, Lufti ... Detroit
Sadowski, Roman ... Detroit
Sage, Bernard A. ... Dearborn
Sage, Edward O. ... (L) Detroit
Sage, Thomas ... Detroit
Sager, E. L. ... Detroit
St. Amour, Hector J. ... Detroit
St. Louis, R. J. ... River Rouge
Sakorraphos, Stelios N. ... Detroit
Salchow, Paul T. ... Detroit
Salowich, John N. ... Allen Park
Saltzstein, Harry C. ... Detroit
Sand, Harry H. ... Detroit
Sander, I. W. ... Detroit
Sanders, Alex W. ... Detroit
Sanderson, Alvord R. ... Grosse Pointe Park
Sanderson, Suzanne ... Detroit
Sandler, Nathaniel ... Detroit
Sands, G. E. ... Detroit
Sandweiss, David J. ... Detroit
Sanford, Hawley S. ... Detroit
Sapala, M. Andrew ... Detroit
Sargent, William R. ... Detroit
Sauk, John J. ... Detroit
Sauter, Simon H. ... Detroit
Savignac, Eugene M. ... Detroit
Scarney, Herman D. ... Detroit
Schaefer, Robert L. ... Detroit
Schaeffer, Martin ... Detroit
Schembeck, I. S. ... Detroit
Schenden, A. J. ... Melvindale

Schiller, A. E. ... Detroit
Schillinger, Harold K. ... Dearborn
Schinagel, Geza ... Detroit
Schirack, Ray ... Detroit
Schkloven, Norman ... Detroit
Schlacht, George F. ... Romulus
Schlafer, Nathan H. ... Detroit
Schlemer, John H. ... Detroit
Schlesinger, Henry ... Detroit
Schmaltz, John D. ... Detroit
Schmidt, Harry E. ... Dearborn
Schmidt, Milton R. ... Trenton
Schmier, Burton L. ... Detroit
Schmitt, Norman L. ... Detroit
Schneck, Robert J. ... Detroit
Schneider, Alex N. ... Detroit
Schneider, Curt P. ... Detroit
Schoenfield, Gilbert D. ... Detroit
Schoor, Robert L. ... (E) Detroit
Schooten, Sarah S. ... Detroit
Schreiber, Frederic ... Detroit
Schroeder, Carlisle F. ... Detroit
Schug, Richard H. ... Highland Park
Schulte, Carl H. ... Detroit
Schultz, Ernest C. ... Detroit
Schultz, Robert F. ... Detroit
Schwartz, Ben ... Detroit
Schwartz, Louis A. ... Detroit
Schwartz, Oscar D. ... Detroit
Schwartzberg, Joseph A. ... Detroit
Schweigert, C. F. ... Detroit
Sciarrino, Stanley V. ... Detroit
Scott, R. J. ... Detroit
Scott, William J. ... Grosse Pointe Farms
Screen, Raymond J. ... Wyandotte
Scruton, Foster D. ... Detroit
Seabury, Frank P. ... Detroit
Secord, Eugene W. ... Detroit
Seeley, James B. ... Dearborn
Seeley, Ward F. ... Detroit
Segar, Lawrence F. ... Detroit
Seibert, Alvin H. ... Grosse Pointe Park
Seiferlein, Archie L. ... Detroit
Selby, C. D. ... Detroit
Sellers, Charles W. ... Detroit
Sellers, Graham ... Detroit
Selling, Lowell ... Detroit
Selman, J. H. ... Detroit
Sewell, George S. ... Detroit
Shafarman, Eugene ... Detroit
Shaffer, Joseph H. ... Detroit
Shaffer, Loren W. ... Detroit
Shafter, Royce R. ... Detroit
Shannon, Wm. F. ... Detroit
Shapiro, I. Allen ... Detroit
Shapiro, Jacob ... Detroit
Shapiro, Oscar U. ... Detroit
Sharrer, Charles H. ... Detroit
Shaw, Norman D. ... Dearborn
Shaw, Robert G. ... (L) Detroit
Shawan, H. K. ... Detroit
Sheldon, John A. ... Detroit
Shelton, C. F. ... Detroit
Sheppard, Emma L. W. ... Center Line
Sherman, Boudana B. ... Detroit
Sherman, Louis L. ... East Detroit
Sherman, Wm. L. ... Detroit
Sherrin, Edgar R. ... Detroit
Sherwood, De Witt L. ... Detroit
Shewchuk, Alexander P. ... Detroit
Shields, W. L. ... Detroit
Shifrin, Peter G. ... Detroit
Shiovitz, Louis ... Detroit
Shippen, M. R. ... Eloise
Shipton, W. Harvey ... Detroit
Shlain, Benjamin ... Detroit
Shoenfield, Adolph ... Detroit
Shore, O. J. ... Detroit
Shotwell, Carlos W. ... Detroit
Shulak, Irving B. ... Detroit
Shumaker, Edw. J. ... Detroit
Shurly, Burt R. ... (E) Detroit
Siddall, Roger S. ... Detroit
Sieber, Edward H. ... Dearborn
Siefert, John L. ... Detroit
Siefert, Wm. A. ... Detroit
Siegel, Henry ... Detroit
Sill, Jack A. ... Detroit
Silverman, I. Z. ... Detroit
Silver, Israel W. ... Detroit
Silverman, M. M. ... Detroit
Simon, Emil R. ... Detroit
Simon, Heinz ... Detroit
Simpson, C. E. ... Detroit
Simpson, H. Lee ... Detroit
Sinclair, James W. ... Detroit
Singer, Floyd W. ... Detroit
Sipola, George W. ... Detroit
Sison, John M. ... Detroit
Sivka, Isidore J. ... Detroit
Sinner, W. Clare ... Detroit
Szycki, Stephen S. ... Detroit
Skilly, E. J. ... Detroit
Sladen, Frank J. ... Grosse Pointe
Slate, Raymond N. ... Detroit

Slaughter, Fred M. ... Detroit
Slaugenhaupt, J. G. ... Detroit
Slazinski, Leo W. ... Detroit
Slipson, Edith ... Detroit
Slevin, John G. ... Detroit
Sliwin, Edward P. ... Detroit
Small, Henry ... Detroit
Smeck, Arthur R. ... Detroit
Smith, Charles E. ... Detroit
Smith, Clarence V. ... Detroit
Smith, Claude A. ... River Rouge
Smith, F. Janney ... Detroit
Smith, Gerrit C. ... Detroit
Smith, Henry L. ... Detroit
Smith, J. Allen ... Detroit
Smith, James A. ... Detroit
Smyka, Edward J. ... Detroit
Smyth, Charley J. ... Eloise
Snedeker, Bernard C. ... Highland Park
Snow, L. W. ... Northville
Snyder, Arthur M. ... Detroit
Sokolov, Raymond A. ... Detroit
Somers, Donald C. ... Detroit
Sonda, Lewis P. ... Detroit
Sorock, Milton L. ... Detroit
Spademan, Loren C. ... Detroit
Spalding, Edward D. ... Detroit
Sparling, Harold I. ... Northville
Sparling, Irene L. ... Northville
Speck, Carlos C. ... Allen Park
Spector, Maurice J. ... Detroit
Spero, Gerald D. ... Detroit
Sperry, Frederick L. ... Detroit
Spiro, Adolph ... Detroit
Springborn, B. R. ... Detroit
Sprunk, Carl ... Detroit
Sprunk, John P. ... Detroit
Spurrier, Ethelbert ... Detroit
Squires, W. H. ... Eloise
Stafford, Frank W. J. ... Detroit
Stalker, Hugh ... Grosse Pointe
Stamell, Meyer ... Detroit
Staniszowski, Casimir ... Detroit
Stanton, James M. ... Detroit
Stanton, Myron ... Detroit
Stapleton, Wm. J., Jr. ... (L) Detroit
Starrs, Thomas C. ... Detroit
Staub, Howard P. ... Detroit
Stearns, Alex B. ... Grosse Pointe Woods
Steele, Hugh ... Detroit
Stefani, E. L. ... Detroit
Stefani, Raymond T. ... Detroit
Stein, Edward ... Detroit
Stein, Albert H. ... Detroit
Stein, Emory ... Detroit
Stein, Saul C. ... Van Dyke
Steinbach, Henry B. ... Detroit
Steinberger, Eugene ... Detroit
Steiner, Gabriel ... Detroit
Steiner, Louis J. ... Detroit
Steinhardt, Milton J. ... Detroit
Stellhorn, Chester E. ... Detroit
Stellhorn, Mary Christine ... Detroit
Sterba, Richard ... Detroit
Sterling, Lawrence S. ... Detroit
Sterling, Robert R. ... Detroit
Stern, Harry L. ... Detroit
Stern, Leonard H. ... Detroit
Stern, Louis D. ... Detroit
Stewart, Harry L. ... Detroit
Stewart, Thomas O. ... Detroit
Stiefel, Daniel M. ... Detroit
Stirling, Alex M. ... Detroit
Stith, Dwight E. ... Detroit
Stobbe, Godfrey D. ... Detroit
Stocker, Harry ... Detroit
Stockwell, B. W. ... Detroit
Stokfisz, T. ... Detroit
Stout, Lindley H. ... Detroit
Straith, Claire L. ... Detroit
Strand, Martin E. ... Dearborn
Stricker, Henry D. ... Detroit
Strickroot, Fred L. ... Detroit
Strohschein, Don F. ... Detroit
Stryker, Walter ... Detroit
Stubbs, C. T. ... Detroit
Stubbs, Harold W. ... Detroit
Stuecheli, Milton B. ... Detroit
Sugar, David I. ... Detroit
Sugar, H. Saul ... Detroit
Sugarman, Marcus H. ... Detroit
Sullivan, Hugh A. ... Detroit
Summers, Wm. A. ... Detroit
Summers, Wm. S. ... Detroit
Surbis, John P. ... Detroit
Sutherland, J. M. ... Detroit
Suwinski, Raymond H. ... Detroit
Swanson, Carl W. ... Detroit
Swanson, Cleary N. ... Detroit
Swanson, Robert G. ... Detroit
Sweeny, Donald, Jr. ... Detroit
Swift, Karl L. ... Detroit
Switzer, Bertrand C. ... Detroit
Sylvan, Melvin M. ... Van Dyke
Syphax, Charles S., Jr. ... Detroit

Szappanyos, Bela T. ... Detroit
Szedja, J. C. ... Detroit
Szilagyi, Emerick D. ... Detroit
Szlachetka, Vincent E. ... Detroit
Szladek, Frank J. ... Wyandotte
Szmigiel, A. J. ... Detroit

Tamblyn, E. J. ... Detroit
Tann, H. E. ... Detroit
Tapert, Julius C. ... Detroit
Tasker, Helen ... Detroit
Tassie, Ralph N. ... Detroit
Tatelis, Gabriel ... Detroit
Taylor, Aaron ... Detroit
Taylor, Ivan B. ... Detroit
Taylor, Nelson M. ... Grosse Pointe
Taylor, Reu Spencer ... (L) Detroit
Tear, Malcolm J. ... Detroit
Teitelbaum, Myer ... Detroit
Tenaglia, Thomas A. ... Ecorse
Tenerowicz, Rudolph G. ... Detroit
Test, Frederick C., II ... Detroit
Texter, Elmer C. ... Detroit
Thaler, Wm. J. ... Detroit
Thompson, Alderman ... Detroit
Thompson, Arthur Lee ... Detroit
Thompson, H. E. ... Detroit
Thompson, H. O. ... Detroit
Thompson, W. A. ... Detroit
Thomson, Alexander ... (E) Detroit
Thornell, Harold E. ... Detroit
Thosteson, George C. ... Detroit
Tichenor, E. D. ... Detroit
Toepel, Otto T. ... (E) Detroit
Tolle, Charles E. ... Detroit
Tomsu, Charles L. ... Detroit
Top, Franklin H. ... Detroit
Townsend, Frank M. ... Detroit
Trask, Harry D. ... Detroit
Tregenza, W. Kenneth ... Detroit
Troester, George A. ... Detroit
Trombino, James F. ... Detroit
Trombley, Bryan ... Detroit
Trombley, Joseph J., Jr. ... Detroit
Troxell, Emmett C. ... Detroit
Truszkowski, E. G. ... Hamtramck
Trythall, S. W. ... Detroit
Tulloch, John ... Detroit
Tupper, Roy D. ... Detroit
Turbett, Claude W. ... Detroit
Turcotte, Vincent J. ... Detroit
Turkel, Henry ... Detroit
Turnbull, Jack V. ... Dearborn
Tuttle, Wm. M. ... Detroit
Tyson, Wm. E. E. ... (L) Detroit

Ujda, Chester J. ... Wayne
Ulbrich, Henry L. ... Detroit
Ulrich, Willis H. ... Detroit
Umphrey, Clarence E. ... Detroit
Usher, Wm. Kay ... Detroit

Vale, C. Fremont ... Detroit
Van Baalen, M. R. ... Detroit
Van Gundy, Clyde R. ... Detroit
Van Heldorf, Harry ... Detroit
Van Nest, A. E. ... Detroit
Van Rhee, George ... Detroit
Van Riper, Steven L. ... Detroit
Vardon, Edward M. ... Detroit
Vasu, V. O. ... Detroit
Vergosen, Harry E. ... Detroit
Vogelin, Adolph E. ... Detroit
Vogel, Hymen A. ... Detroit
Vokes, Milton D. ... Detroit
Von Der Heide, E. C. ... Detroit
Vossler, A. E. ... Detroit
Vreeland, C. Emerson ... Detroit

Waddington, Joseph E. G. ... (E) Detroit
Waggoner, C. Stanley ... Detroit
Waggoner, Lyle G. ... Detroit
Wainger, M. J. ... Detroit
Wainstock, Michael ... Detroit
Wakeman, E. M. ... Dearborn
Waldbott, George L. ... Detroit
Walker, Enos G. ... Detroit
Walker, Leo Whitney ... Detroit
Walker, Roger V. ... Detroit
Wallace, S. Willard ... Detroit
Walls, Arch ... Detroit
Walser, Howard C. ... Detroit
Walsh, Charles R. ... Detroit
Walsh, Francis P. ... Detroit
Walters, Albert G. ... Detroit
Waltz, Frank D. B. ... Detroit
Waltz, Paul J. ... Detroit
Ward, George F. ... Detroit
Warden, Horace F. W. ... Detroit
Warner, Harold W. ... San Diego, Cal.
Warner, P. L. ... Detroit
Warner, Wm. J. ... Detroit
Warren, Irving A. ... Detroit
Warren, Wardsworth ... Detroit
Wasserman, Lewis C. ... Detroit
Waszak, Charles J. ... Detroit
Watson, Douglas J. ... Detroit
Watson, Harwood G. ... Dearborn

Watson, J. Edwin....Detroit
Watson, Robert W....Highland Park
Watts, Frederick B....Detroit
Watts, John J....Detroit
Wayne, M. A....Detroit
Weaver, Clarence E....Detroit
Weaver, Delmar F....Grosse Pointe
Weber, Karl W....Detroit
Webster, John E....Detroit
Weed, Milton R....Detroit
Wehenkel, Albert M....Detroit
Weiner, M. B....Detroit
Weingarden, David H....Detroit
Weinstein, Jacob....Detroit
Weisberg, A. Allen....Detroit
Weisberg, Harry....Detroit
Weisberg, Jacob....Detroit
Weisenthal, Irvin....Detroit
Weiser, Frank A....Detroit
Weiss, C. P....Detroit
Weiss, J. G....Detroit
Welch, John H....Detroit
Weller, Charles N....Detroit
Wells, Martha....Detroit
Weltman, Carl G....Detroit
Wendel, Jacob S....Detroit
Wenzel, Jacob F....Detroit
West, Howard G....Detroit
Weston, Bernard....Detroit
Weston, Earl E....Detroit
Weston, Horace L....Detroit
Westover, Charles....Plymouth
Weyher, Russell F....Detroit
Whalen, Neil J....Detroit
Wharton, Thomas V....Wyandotte
Whinnery, Randall A....Detroit
White, Milo R....Detroit
White, Milton W....Detroit
White, Prosper D., Jr....Detroit
White, Theodore M....Detroit
Whitehead, L. S....Detroit
Whitehead, Walter K....Detroit
Whiteley, Robert K....Detroit
Whitney, Elmer L....Detroit
Whitney, Rex E....Detroit
Whittaker, Alfred H....Detroit
Wiant, John L....Detroit
Wiant, R. E....Detroit
Wickham, A. B....(L) Detroit
Wiechowski, Henry E....Detroit
Wiener, I....Detroit
Wietersen, Fred K....Birmingham
Wight, Fred B....Detroit
Wilcox, Leslie F....Detroit
Wilkinson, Arthur P....Detroit
Williams, C. J....Detroit
Williamson, John G....Dearborn
Wills, J. N....Detroit
Wilner, Irvin....Detroit
Wilson, Gerald A....Detroit
Wilson, M. C....Detroit
Wilson, Stuart C....Detroit
Wilson, Walter J....(L) Detroit
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Wishropp, Edward A....Grosse Pointe
Wisner, Harold E....Detroit
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Witter, Joseph A....Detroit
Witus, Carl....Detroit
Witus, Morris....Detroit
Witwer, Eldwin R....Detroit
Wolfe, Max O....Detroit
Wollank, Helen Wilson....Detroit
Wollenberg, Robert A. C....Detroit
Wood, George P....Detroit
Wood, Kenneth A....Detroit
Wood, Wilford C....Detroit
Woodburne, H. L....Detroit
Woodry, Norman L....Detroit
Woods, H. B....Brown City
Woods, W. Edward....Detroit
Woodworth, Wm. P....Detroit
Worzniak, Joseph J....Wyandotte
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Young, Donald A....Detroit
Young, Donald C....Detroit
Young, Lloyd B....Detroit
Young, Viola M....Detroit
Youngman, D. C....Detroit

Zabinski, Edward J....Detroit
Zbudowski, A. S....Hamtramck
Zbudowski, Myron R....Hamtramck
Zemens, Joseph L....Grosse Pointe Woods
Zerhi, Victor....Lincoln Park
Zielinski, Charles J....Detroit
Zimmerman, R. L....Detroit
Zinn, George H....Detroit
Zinterhofer, John....Detroit
Zinterhofer, Louis....Detroit
Zlatkin, Louis....Detroit
Zonnis, Marian....Detroit
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Wm. De Kleine, M.D., Commissioner, Lansing, Michigan

STUDY MICHIGAN SALMONELLA

To conduct a study of the incidence of Salmonella infections in farm, pet and wild animals and the possible relationship to infection in humans, A. H. Wolff, D.V.M., has been assigned to the Bureau of Disease Control, Michigan Department of Health, by the United States Public Health Service. The Bureau of Laboratories is co-operating with him in the study.

The project is one of several recently inaugurated by the Veterinary Public Health Section of the United States Public Health Service directed toward the prevention of animal diseases transmissible to humans.

Approximately 200 types or varieties of Salmonella are known to date. Very few of these occur exclusively in man. The vast majority of the organisms primarily infect animals and birds. Aside from their veterinary significance, these animal infections are important in human medicine when they are transferred by meat, milk, and eggs, and perhaps by direct contact, to man.

Before the diseases can be adequately controlled, more data on the incidence in man and animal as well as the mode of transmission between man and animal must be obtained. The current investigation involves the incidence of Salmonella in dogs and possible relationship to infections in humans. The study will eventually include the incidence of the infections in other animals and in the various foods derived from animals.

Infants and the very old are more susceptible to infection by this germ than are people of other ages. The Salmonella organism is sometimes responsible for outbreaks of infantile diarrhea. Generally speaking, the symptoms of the illness vary from a gastro-enteritis to a severe blood infection with septic complications.

Thorough cooking or pasturization of animal or poultry food products (meat, milk and egg products), and adequate refrigeration provide the greatest measure of protection against infection with Salmonella organisms.

NO POLIO CROSS INFECTION IN HOSPITALS

No case of a cross infection from a poliomyelitis patient in a Michigan hospital has been reported since the decision of the Michigan Hospital Superintendents to admit polio patients to general hospitals a year ago.

DISEASE REGULATIONS PRINTED

The 1947 issue of the Michigan Regulations for the Control of Communicable Diseases has been sent by the Michigan Department of Health to all practicing physicians of the state. Anyone not receiving a copy may obtain it directly by writing to the Department.

ACCIDENTS FOURTH IN DEATH CAUSES

Accidents took the lives of one out of every 15 persons who died in Michigan in 1946. They constituted the fourth cause of death. Home accidents took 1,385 lives, and motor accidents, 1,451 lives, of which 503 were pedestrians. Total deaths attributable to accidents in the state last year were 3,778.

BAD FOR CHILDREN

While preventive and curative medicine, since 1924, have tripled the chance of a Michigan child to live until he is fourteen years of age, the chance that he will die by accident has doubled since that time. Accidents caused every third death among Michigan children last year.

MEN AND BOYS DROWN

Nine out of every ten persons who drown in Michigan are men and boys. Only twenty-five women and girls were among the 265 persons who drowned in Michigan in 1946. Twelve of these were girls under ten years of age. Two-thirds of drownings in Michigan occur during the summer months.

RABIES CONTINUES TO INCREASE

The incidence of rabies in fourteen southern Michigan counties continues to increase. A total of 166 cases of rabies were reported in the first five months of this year, and six counties had established dog quarrantine.

PREPARE FOR SCHOOL

The Department through newspapers and radio has advised parents of children who will enter school for the first time this fall to take the children to family physicians in June for complete physical checkup and for booster doses of immunizing agents.

INCIDENCE OF COMMUNICABLE DISEASE

Disease	*May 1947*	*May 1946*	*7-year median*
Diphtheria	17	25	14
Gonorrhea	938	1085	870
Lobar Pneumonia	61	93	153
Measles	623	5134	3930
Meningococcic meningitis	11	21	19
Pertussis	1030	607	915
Poliomyelitis	2	1	0
Scarlet fever	503	755	1062
Syphilis	1379	1478	1345
Tuberculosis	452	450	511
Typhoid fever	5	4	4
Undulant fever	28	15	11
Smallpox	0	0	1

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What's What

Jay C. Ketchum, Executive Vice President of Michigan Medical Service, spoke on "Voluntary Insurance Plan" at the hearings on S.545 in Washington, May 23.

* * *

Toll of War—The total war cost to the United States is estimated at $330,000,000,000 or $2,233.94 per capita. To Canada: $20,255,865,966, or $1,688 per capita.

* * *

F. W. Hartman, M.D. and P. C. Martineau, M.D., Detroit, are authors of an original article, "Extensive Cutaneous Burns," which appeared in JAMA of May 31.

* * *

H. M. Miller, M.D., Detroit, is the author of an article, "General Practice in a Large Hospital," which was published in JAMA of May 3. It is a report of eight years' experience in the operation of such a Section.

* * *

Joseph H. Andries, M.D., and Hugh Harrison, M.D., Detroit, were honored at a banquet sponsored by the St. Joseph's Mercy Hospital Staff commemorating fifty years in practice of these two physicians. Engraved gold watches were presented to the two doctors from the hospital staff.

Wayne University College of Medicine has added the following course to its Postgraduate Continuation Curriculum for the summer quarter:

Allergy Clinic and Conference
Receiving Hospital

Tuesday—8:00 to 11:00 a.m.

Clinic 8-10
Conference 10-11

Fee—$25.00

The course begins July 1 and runs for three months.

H. Marvin Pollard, M.D., Malcolm Block, M.D., and Wm. H. Bachrach, M.D., of Ann Arbor, Michigan, are authors of an original article, "Ulcerative Colitis," which appeared in JAMA of May 24.

* * *

The Third Pan-American Congress of Ophthalmology will be held in Havana, Cuba, January 4-10, 1948. A cordial invitation to all members of the Michigan State

(Continued on Page 862)

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SURGERY—Two-week intensive course in Surgical Technique, starting August 18, September 22, October 20.
Four-week course in General Surgery, starting August 4, September 8, October 6.
Two-week course in Surgical Anatomy & Clinical Surgery, starting July 21, August 18, September 22.
One-week course in Surgery of Colon & Rectum, starting September 15, and November 3.
Two-week course in Surgical Pathology every two weeks.

FRACTURES & TRAUMATIC SURGERY—Two-week intensive course starting October 6.

GYNECOLOGY—Two-week intensive course starting September 22, October 20.
One-week course in Vaginal Approach to Pelvic Surgery, starting September 15 and October 13.

OBSTETRICS—Two-week intensive course, starting September 8, October 6.

MEDICINE—Two-week intensive course, starting October 6.
Two-week course in gastro-enterology, starting October 20.
One-week course in Hematology, starting September 29.
One-month course in Electrocardiography & Heart Disease, starting September 15.
Two-week intensive course in Electrocardiography & Heart Disease, starting August 4.

DERMATOLOGY & SYPHILOLOGY — Two-week course starting October 20.

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(Continued from Page 860)

Medical Society to attend the Congress has been extended by Tomas R. Yanes, M.D., P.O. Box 970, Havana, Cuba, President of the Congress.

* * *

Veterans Administration estimates that the number of living veterans and members of their families will reach a peak of 43 per cent of the nation's population within the next 5 years and decline in percentage thereafter.

* * *

C. P. McCord, M.D., Detroit, received the William S. Knudsen Award for the most outstanding contribution to Industrial Medicine for 1946-47. Congratulations, Dr. McCord!

* * *

Ralph A. Johnson, M.D., Detroit, has been appointed to the Detroit Public Welfare Commission by Mayor Edward J. Jefferies, for the term ending March 1, 1951. Congratulations, Commissioner Johnson!

* * *

William R. Bond, M.D., well known to many Michigan physicians, has been appointed Medical Director of VanPelt and Brown, Inc., Richmond, Va. Dr. Bond is Consultant for the Endocrine Clinic of the Medical College of Virginia.

* * *

W. Leonard Howard, M.D., was appointed Medical Superintendent of Wm. H. Mayberry Sanitarium in May, according to an announcement made by Bruce H. Douglas, M.D., Commissioner of Health of the City of Detroit. Congratulations, Dr. Howard!

* * *

The Congress on Industrial Health proposed for Detroit in October, 1947, has been cancelled, due to conflict with other national health meetings, according to Carl M. Peterson, M.D., Secretary of the AMA Council on Industrial Health.

* * *

Ralph Lee Fisher, A.B., M.D., F.A.C.P., and *Morris Zukerman, A.B., M.D.,* of Detroit, published a paper on "Banti's Syndrome following Prolonged Infectious Hepatitis," with report of two cases in *The American Journal of Digestive Diseases* for November, 1946.

* * *

The annuual meeting of Michigan Medical Service is to be held in the Ballroom of the Pantlind Hotel, Grand Rapids, on Monday, September 22, 2:00 p.m. The MMS membership comprises the members of the MSMS House of Delegates plus the members of the Board of Directors of Michigan Medical Service.

* * *

The Press Relations Committee for the 82nd Annual Session of the Michigan State Medical Society scheduled for Grand Rapids, September 23-26, appointed by B. R. Corbus, M.D., chairman of the Arrangements Committee, is as follows: C. A. Payne, M.D., chairman; G. T. Aitken, M.D. and J. R. Brink, M.D., all of Grand Rapids.

(Continued on Page 864)

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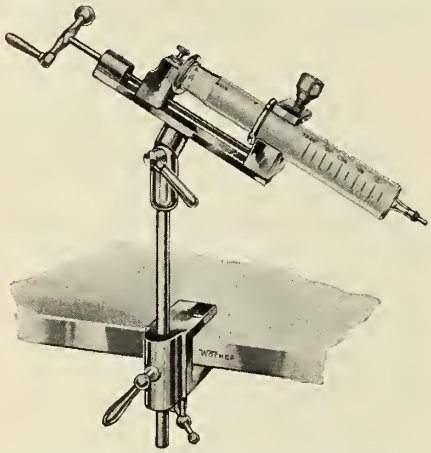

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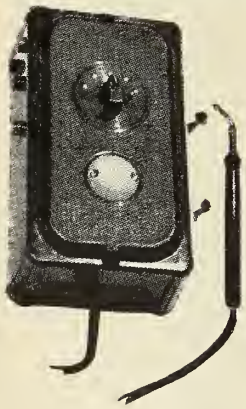

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(Continued from Page 862)

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* * *

Indiana recently passed a law requiring annual registration of physicians, effective July 1, 1947. Any Michigan practitioners of medicine who have Indiana licenses should write the Indiana State Board of Medical Registration and Examination, 416 K. of P. Bldg., Indianapolis 4, Indiana, for a copy of the "application for annual registration of license to practice the healing art in the State of Indiana." The nonresident fee is $10.

* * *

Amendments to MSMS Constitution and By-Laws. A special MSMS Committee has been appointed to study the MSMS Constitution and By-Laws with a view to presenting recommendations for any necessary amendments to the House of Delegates in Grand Rapids next September. Chairman T. K. Gruber, Wayne County General Hospital, Eloise, Mich., would appreciate receiving any suggestions for proposed amendments to the MSMS Constitution or By-Laws.

* * *

Availability of doctors.—It is seriously recommended that arrangements be made in all localities so that one or more doctors of medicine are available on the "day off" usually taken by the medical profession in the community. This is to protect the medical profession from the criticism—frequently printed in newspapers—that "no doctors were available when the accident occurred, although 18 were called, etc., etc." Definite notification to the newspapers of arrangements made by county medical societies or communities along this line should be made.

* * *

Wayne University Alumni Association will hold "open house" in Parlor D, Mezzanine Floor, Pantlind Hotel, Grand Rapids, during the 1947 Annual Session of the Michigan State Medical Society, from Tuesday noon to Friday noon, September 23-26.

An exhibit of college yearbooks and alumni materials will be displayed. The headquarters will be manned by Homer D. Strong, M.D., Head of the Alumni Affairs of Wayne University.

All alumni of Wayne University College of Medicine are cordially invited to visit the headquarters in The Pantlind during the MSMS convention.

* * *

The Michigan State Medical Society has appointed a Special Committee of The Council to study the Medical Practice Act of Michigan. The personnel of the committee, which plans to report to the MSMS House of Delegates in September, 1947, is composed of: Harold L. Morris, M.D., Detroit; F. J. O'Donnell, M.D., Alpena; C. W. Colwell, M.D., Flint, L. A. Drolett, M.D., Lans-

(Continued on Page 866)

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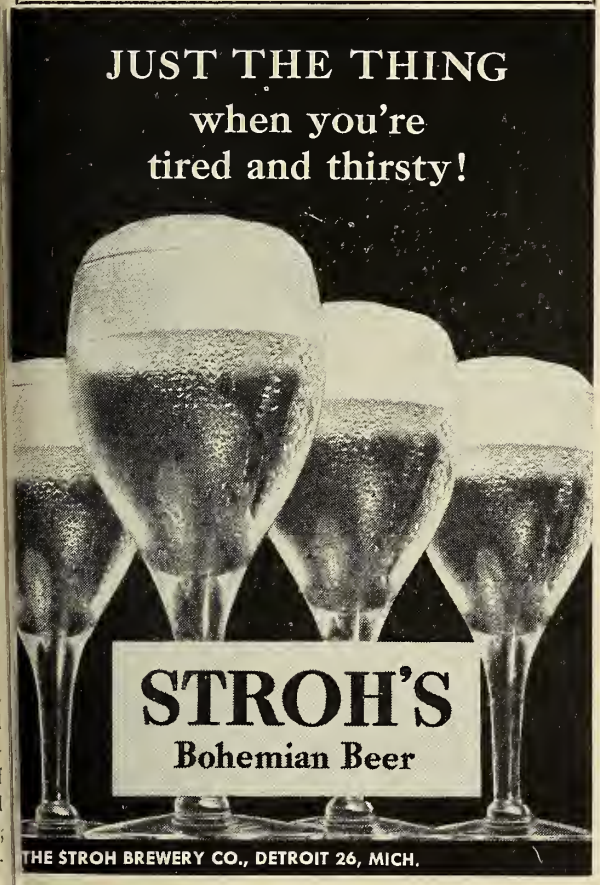

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ing, L. F. Foster, M.D., Bay City, Wilfrid Haughey, M.D., Battle Creek, W. R. Torgerson, M.D., Grand Rapids, and J. Joseph Herbert, LL.B., Manistique, Advisor.

* * *

The International College of Surgeons (United States Chapter) will hold its 12th Assembly at the Palmer House, Chicago, September 28-October 4, 1947. Among fifty-two internationally famous surgeons who will present scientific papers are: Hamilton Bailey, London, England; Zachary Cope, London, England; Professor Raymond Darget, Bordeaux, France; Leon Gillis, Roehampton, England; Basil Hughes, London, England; Ambassador Oscar Ivanissevich, Buenos Aires, Argentina; William Oliver Lodge, Halifax, England; Professor Felix Mandl, Jerusalem, Palestine; J. Almeida Rios, Rio de Janeiro, Brazil; August Maria Sisson, Porto Alegre, Brazil; and Alex W. Spain, Dublin, Ireland.

* * *

What is the difference between Membership and Fellowship in the American Medical Association? AMA membership comes automatically to any member certified by a county medical society to the state medical society, which in turn certifies his name to the AMA; Fellowship is a privilege conferred by the AMA Judicial Council on those members who apply for Fellowship on the prescribed form and subscribe to the AMA Journal, paying the annual Fellowship dues for the current year. Attendance at the Scientific Assembly and all other privileges of the AMA are granted to Fellows.

The work of the AMA is outlined in a concise booklet entitled "The Individual Physician" which may be procured free by writing the AMA, 535 No. Dearborn St., Chicago 10, Ill.

* * *

The following bills were passed by the Michigan Legislature of 1947:

H.B. 451.—This Act will implement in Michigan the provisions of the Federal Hospital Survey and Construction Act. As passed, the law is almost verbatim with the recommendations made by the MSMS Executive Committee of The Council. It calls for a Director to be appointed by the Governor to administer the act with the help of an Advisory Council. No crippling amendments were included in the bill as finally passed in spite of sundry attempts of a cultist organization to use it as an opening wedge for entrance into medical hospitals. The Act specifically provides against any attempt to use the provisions of the law to socialize medicine. Much of the credit for passage of this Act is due Mr. Howard Estes of Birmingham, the introducer of the bill.

S.B. 274, 275.—As passed these Acts will raise hospital rates under the Afflicted and Crippled Children's Act from $7 to $11 and the maximum surgical fee in the Michigan Crippled Children Commission fee schedule from $75 to $90 (a 20 per cent increase).

S.B. 201.—As passed this law will license and regulate Vivisection. No crippling amendments were made to

(Continued on Page 868)

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(Continued from Page 866)

bill as originally drafted, despite bitter activity by anti-vivisectionists aided by the vigorous promotions of a chain newspaper.

S.B. 378.—This Act will require immunization against diphtheria, whooping cough and smallpox as a condition precedent to entrance in school. (Vetoed by the Governor.)

* * *

Marriages Increased.—Cupid, Justices of the Peace, and Ministers came into their own again in Michigan cities in 1946, it is indicated by figures released this week by the Bureau of Records and Statistics of the Michigan Department of Health.

The 1946 marriage license figures of Flint and Grand Rapids exceeded their 1945 figures by greater percentages than were recorded in any other major city in the United States. Detroit was not far behind.

Flint leads the cities of over 100,000 population in the nation with a 73.3 per cent increase. Grand Rapids was second in the nation with 72.5 per cent increase. Detroit's increase was 53.9 per cent.

Return of soldiers from the European and Pacific theaters is believed to have boosted the number of licenses issued. All three of the Michigan towns which are included in the cities over 100,000 population showed decrease in marriage licenses issued from 1941 to 1944, with Grand Rapids showing the greatest decline.

The second annual postgraduate course in Diseases of the Chest, sponsored by the American College of Chest Physicians, will be held September 15-20, 1947, at the Municipal Tuberculosis Sanitarium, Chicago, Illinois. Tuition $50.00. For information, write American College of Chest Physicians, 500 N. Dearborn Street, Chicago 10, Illinois.

* * *

L. M. Snyder, M.D., has joined the law firm of Foster, Cummins, Snyder, Cameron and Foster, 705 American State Bank Bldg., Lansing, and is devoting his full time to the practice of legal medicine.

* * *

Wolff W. Zuelzer, M.D., Detroit, is the author of an original article "Pathogenesis of Anemia" which appears in JAMA of July 19.

* * *

The Chicago Ophthalmological Society will give a 40-hour refresher course, December 8 to 13, inclusive. The faculty will include members of the Eye Department of The University of Chicago, The University of Illinois, Loyola University, Northwestern University and staff members of all of the principal hospitals of Chicago. Instruction will consist of didactic and practical courses, emphasis being placed on the practical courses given to small groups. Physicians practicing ophthalmology and eye, ear, nose and throat are eligible for the course. The fee will be $100.00. For details write to the registrar, Miss Maude Fairbairn, 8 W. Oak Street, Chicago, Illinois.

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Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

EXPERIENCES WITH FOLIC ACID. By Tom D. Spies, M.D., Associate Professor of Medicine, University of Cincinnati School of Medicine; Director of the Nutrition Clinic, Hillman Hospital, Birmingham, Alabama. Chicago: The Yearbook Publishers, Inc., 1947. Price $3.75.

Folic acid used in the treatment of macrocytic anemia is one of the great advances of the age of great progress in medicine. The rapidity of this advance is unparalleled. This book outlines the methods of research, selection of cases and their response to folic acid. Pernicious anemia is now well under control. The internist and the general practitioner who treat these patients need this book. It is a stimulating brochure.

REHABILITATION THROUGH BETTER NUTRITION. University of Cincinnati Studies in Nutrition at the Hillman Hospital, Birmingham, Alabama. By Tom D. Spies, M.D., from the Department of Internal Medicine, University of Cincinnati College of Medicine. 94 pps. 50 illus. Philadelphia and London: W. B. Saunders Company, 1947. Price $4.00.

This is a book on practical therapeutics and is presented as an aid to study. Cases are reported of pellagrous dermatits traceable to deficient diet, cured by correcting the diet. A study was made at Birmingham, Alabama, involving dietary deficiencies; 893 cases. There were 377 cases of pellagrous dermatitis; 531, conjunctival injection; 330, edema of the tongue; 102, paresthesias of the leg, to mention a few. Diets are given.

The book is a really interesting study.

NUTRITIONAL AND VITAMIN THERAPY IN GENERAL PRACTICE. By Edgar S. Gordon, M.D., Ph.D., Associate Professor of Medicine, University of Wisconsin. Chicago: The Year Book Publishers, Inc., 1947. Price $5.00.

This is a handbook on the subject of nutrition and vitamin therapy. Chapters are devoted to the various vitamins, their source in food, the symptoms and diagnosis of their deficiencies. There are also chapters about the various items of nutrition, minerals, fat, carbohydrate, proteins.

The fuel foods receive attention, as well as weight control, dental problems and a special chapter on the economic side of clinical nutrition. This is about the most useful book we have seen on the vitamins and their actual understanding. It is well worth a place on the doctor's shelves.

ESSENTIALS OF ENDOCRINOLOGY. By Arthur Grollman, Ph. D., M.D., F.A.C.P., Professor of Medicine and Chairman of The Department of Experimental Medicine, The Southwestern Medical College; Attending Physician and Consultant in Endocrinology, The Parkland Hospital, Dallas, Texas; Second Edition, Revised and Enlarged. 132 illustrations. Philadelphia: J. B. Lippincott Co., 1947. Price $10.00.

This book is a complete exposition of what is known and usable in medical practice regarding the so-called endocrine glands: the hypophysis-anterior lobe, posterior lobe, the pineal body, the thyroid, parathyroid glands, the thymus, the pancreas, the adrenal glands, the hormones of the reproductive organs, and hormones from non-endocrine organs. The pituitary and its effects on the human body and behavior when not normal is a fascinating and compelling study as well as a necessary part of our armamentarium. The same is true of the thyroid, and the late work on sex harmones is just as revealing. This book is the best exposition of endocrine study, effect and therapy we have seen.

OBSTETRICAL PRACTICE. By Alfred C. Beck, M.D., Professor of Obstetrics and Gynecology, Long Island College of Medicine, Obstetrician and Gynecologist-in-chief, Long Island College Hospital, Brooklyn. More than one thousand illustrations. Fourth Edition. Baltimore: The Williams & Wilkins Co., 1947. Price $7.00.

Primarily written for the undergraduate students and younger practitioners, the essentials and principles of obstetrical practice are always foremost, advocating and describing the well-tried and safe procedures, both for mother and child. Prenatal care is especially emphasized. The anatomy, diagnosis, measurements and the

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mechanism of labor are extensively discussed and profusely illustrated. Toxemias and their treatment get sufficient attention. Also discussed are complications and their management, with concise description of forceps delivery, versions, cesarean section and methods that have proven safest and most satisfactory. A new chapter is introduced on analgesia, amnesia and anesthesia, and it is conservative. Biotics and chemotherapy as they apply to obstetrics, syphilis in the mother, et cetera are included. A very satisfying text.

PRACTICAL PHYSIOLOGICAL CHEMISTRY. By Philip B. Hawk, Ph.D., President, and Bernard L. Oser, Ph.D., Director, Food Research Laboratories, Inc., New York; and William H. Summerson, Ph.D., Associate Professor of Biochemistry, Cornell University Medical College, New York. 12th Edition. 5 color plates; 329 illus.; 1323 pages. Philadelphia: The Blakiston Co., 1947. Price $10.00.

This standard and long-used textbook on physiological chemistry has been entirely rewritten in the light of recent advances in laboratory methods, investigative research and new discoveries. The structure of the protein molecule, the basis for all physiological chemistry, is well illustrated, including the simplest forms and the additions which build up to our complicated albumins with their side chains. Throughout the book new chemical entities are diagrammed as well as giving the formulas. Blood analysis has much new material, methods and text. A very considerable part is devoted to vitamins and deficiency disease.

This book is necessary for every laboratory, private hospital or commercial.

PHYSICIAN'S HANDBOOK. Fourth Edition. By John Warkentin, Ph.D., M.D., and Jack D. Lange, M.S., M.D., Chicago: University Medical Publishers, 1947. Price $1.50.

This is a convenient small handbook about 4 inches wide, consisting of 282 pages printed in reduced size typewriter type. It covers laboratory techniques, skin tests, sero-diagnosis, parasites, basal metabolism, what to do in diabetic emergencies or hemolytic shock. It tells how to do a lumbar puncture and gives an interpretation of the Widal test. It is a compend of the laboratory and investigation things to be done in making a diagnosis, compact, and may be carried in the pocket.

RH . . . ITS RELATION TO CONGENITAL HEMOLYTIC DISEASE AND TO INTRAGROUP TRANSFUSION REACTIONS. By Edith L. Potter, M.D., Ph.D., Assistant Professor of Pathology, Department of Obstetrics and Gynecology, The University of Chicago and the Chicago Lying-In Hospital. Chicago: The Year Book Publishers, Inc., 1947. Price $5.50.

Dr. Potter has made this new subject clear and timely. The Rh factor was discovered in 1941, and its meaning and control have been an ever-present problem. This Rh factor has given the answer to some strange manifestations. The material in this volume is based on studies of about 40,000 mothers at Chicago Lying-in Hospital, covering 170 deaths from hemolytic disease over a period of twelve years. Any doctor doing obstetrics must have the information contained in this book, which is well presented. For those wishing a more extended study, there is a bibliography of 794 references. Practically a must, if one is to be well informed.

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R. B. Kennedy, M.D.....Detroit
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Kenneth Wells, M.D.....Spring Lake

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(Continued on Page 880)

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H. A. Kemp, M.D.....Detroi
R. M. McKean, M.D.....Detroi
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LeMoyne Snyder, M.D. (1948)....Lansin

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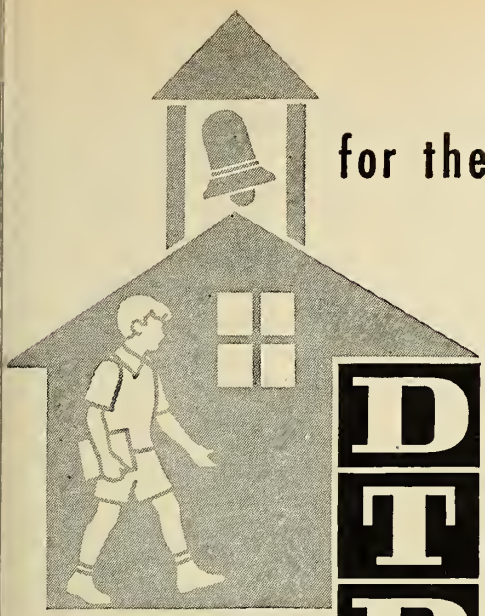
C. L. Weston, M.D.....Owos
G. A. Zindler, M.D.....Battle Cre

*Deceased



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(Continued from Page 878)

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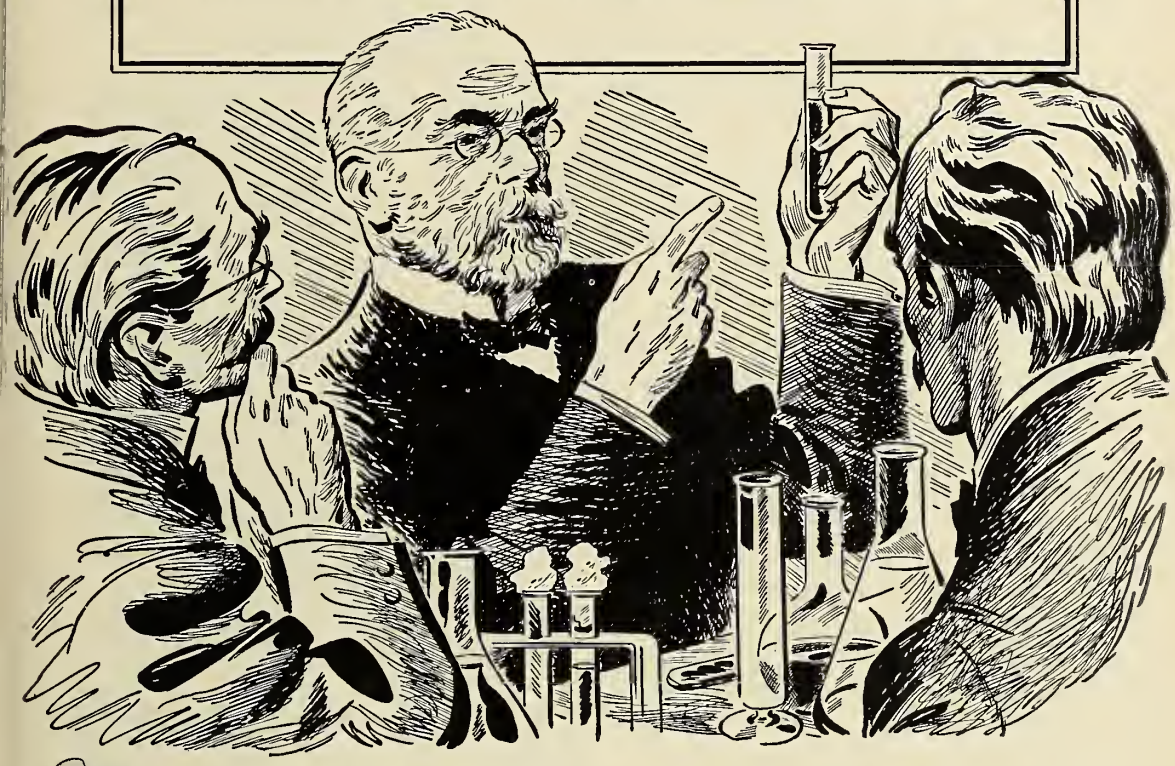
Say you saw it in the Journal of the Michigan State Medical Society

Experience is the Best Teacher

Robert Koch (*1843-1910*) **proved it in bacteriology...**

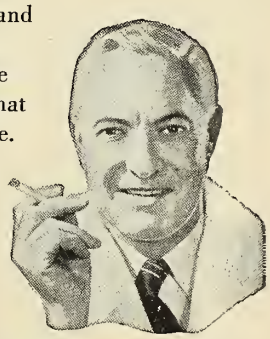
Koch showed in his postulates that he knew the value of experience: Specificity is demonstrated only when the microorganism (1) is present in all cases of the disease, (2) can be cultivated in pure culture, (3) produces the disease in susceptibles on inoculation, and (4) can be recultivated in pure culture.



Yes, and experience is the best teacher in smoking too!

The wartime cigarette shortage was a real experience for smokers. Millions of people smoked whatever brand was available—more different brands than they might ordinarily have tried in years. And from that experience so many more smokers chose Camel as their cigarette that today more people are smoking Camels than ever before.

But, no matter how great the demand, we don't tamper with Camel quality. Only choice tobaccos, properly aged, and blended in the time-honored Camel way, are used in Camels.



According to a recent Nationwide survey:

MORE DOCTORS SMOKE CAMELS

than any other cigarette

R. J. Reynolds Tobacco Company
Winston-Salem, North Carolina

POSTGRADUATE CONTINUATION COURSES

Wayne University College of Medicine

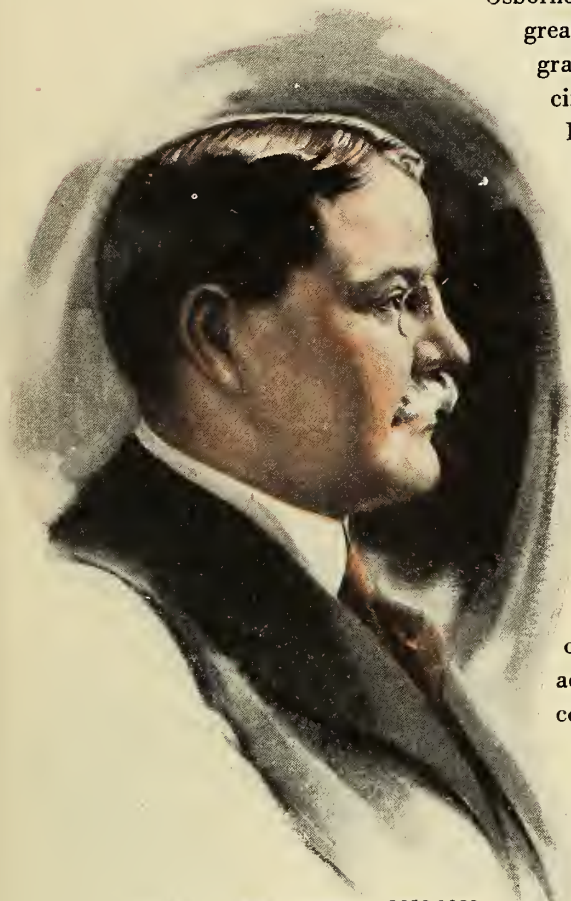
Quarter September 15—December 6, 1947

These courses are open to all qualified persons.

Registration for these courses can be made in the office of Postgraduate Medical Education at the College of Medicine, 1512 St. Antoine, *before* September 13.

	ANATOMY		
Human Inheritance	College of Medicine	Tues. & Thurs. 2-3	$25.00
Readings in Physical Anthropology	College of Medicine	Tuesday 4-5	$25.00
	BACTERIOLOGY		
Newer Bactericidal Agents	College of Medicine	Monday 4-5	$15.00
	PATHOLOGY		
Beginning Hematology	College of Medicine	Friday 1-5	$35.00
Advanced Hematology	College of Medicine	Monday 1-5	$35.00
Surgical Pathology	College of Medicine	Wednesday 1-5	$35.00
	PHARMACOLOGY		
Survey	College of Medicine	Thursday 3-4	$15.00
Seminar	College of Medicine	Thursday 4-5	$15.00
Electropharmacology	College of Medicine	Arranged	$25.00
Autonomic Nervous System	College of Medicine	Arranged	$15.00
	PHYSIOLOGICAL CHEMISTRY		
Seminar	College of Medicine	Wednesday 4-5	$15.00
	PHYSIOLOGY		
Endocrinology	College of Medicine	Tues. 4-5 Fri. 4-6	$35.00
	DERMATOLOGY AND SYPHILOLOGY		
Seminar	Receiving Hospital	Wednesday 10-11:30	$15.00
Conference on Venereal Diseases	Social Hygiene Clinic	Thursday 4-5:30	$15.00
	INTERNAL MEDICINE		
Medical Pathologic Conference	Receiving Hospital	Saturday 11-12	$15.00
	Wayne County General	Thursday 11-12	$15.00
Diagnostic Conference	Wayne County General	Tuesday 4-5	$15.00
Beginning EKG	Wayne County General	Friday 11-12	$15.00
Gastroenterology Clinic Hematology Clinic	Receiving Hospital	Alternate Wednesdays 1-2	$15.00
Medical X-Ray Conference	Receiving Hospital (Limited to 10)	Tuesday 11-12	$15.00
	Wayne County General	Friday 1-2	$15.00
Allergy Clinic and Conference	Receiving Hospital	Tuesday 8-11	$25.00
	SURGERY		
Seminar	College of Medicine (Limited to 20)	Thursday 4-5	$15.00

Men and Amino Acids



THOMAS BURR OSBORNE—1859-1929

Osborne's forty years of research effort contributed a great deal to our modern knowledge of proteins. On graduating from Yale University, he studied medicine for a year, then took a Ph.D. in chemistry; in 1886 he began his lifework as a staff member at the Connecticut Agricultural Experiment Station under Professor S. W. Johnson. His work on vegetable proteins was presented in an important series of papers dealing with the proteins of no less than 32 edible and other seeds. He revealed the inadequacy of characterizing protein preparations solely on the basis of their elemental composition; indicated that most of the known proteins could be classified by methods of amino acid analysis and by their physical properties; demonstrated that different types of plant and animal cells have distinctive protein patterns. With Mendel, he showed that the wide variations in nutritive value of different proteins were related to their amino acid content, and introduced the protein efficiency concept, about which much work in protein nutrition is now centered. With H. Gideon Wells, he investigated anaphylactogenic effects of vegetable proteins. The American Association of Cereal Chemists founded the Thomas Burr Osborne gold medal in recognition of his valuable work in cereal chemistry. He ranks, with Fischer and Kossel, among the greatest pioneers of protein research.

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You and Your Business

EMIC ENDED

The Emergency Maternal and Infant Care Program was liquidated by Congress on July 1, 1947. This wartime federal social experiment that snowballed into a taxpayers' nightmare was looked upon by many persons as the dress rehearsal of complete state medicine. Its flaws were many, its greatest value was the attention it spotlighted on the inadequacies, dangers, and especially the insidious encroachments of socialized medicine.

As a result of action taken by Congress, the following policy on eligibility for Emergency Maternity and Infant Care is announced:

The Michigan Department of Health may make payment for medical, hospital and nursing maternity care of the wife of an enlisted man in one of the eligible pay grades *only* if the wife becomes pregnant prior to July 1, 1947. Since pregnancy rarely exceeds 280 days, the Michigan Department of Health will not authorize payment for maternity care if the baby is expected after April 4, 1948. The expected date of confinement as designated by the attending physician on the application will be used in determining eligibility.

If the eligible mother is delivered on or before April 4, 1948, her infant will be eligible to receive protective treatments against diphtheria, whooping cough and smallpox, and medical, hospital and nursing care for illness until he is one year of age. Therefore, the last authorizations to be made under the EMIC program will be for care of illnesses given eligible infants on April 4, 1948.

We will appreciate having physicians submit reports and invoices for services rendered promptly so that cases kept open for payment may be closed.

Goldie B. Corneliuson, M.D.,
Director Bureau of Maternal and Child Health

* * *

CONGRESS CLAMPS ON PROPAGANDISTS IN GOVERNMENT

The U. S. House of Representatives Committee on Expenditures in the Executive Departments, under the Chairmanship of Congress Harness of Indiana, has begun an investigation of activities of government employes in what they characterized as propaganda.

The first witnesses called were two top officials in the United States Public Health Service. They were questioned as to their authority for appearing at certain workshop conferences, which allegedly encouraged socialized medicine, held during the last year in different places in the United States. They were asked to describe what occurred at these conferences and what part they took. The Committee announced that it will continue its investigation.

* * *

STATE VS. COUNTY SCHEDULES

The 1947 amendments to the Afflicted-Crippled Children Acts, which adjust the top limitation on medical fees to ninety dollars did *not* eliminate the county contractural clause.

This clause limits the State's payments for medical-surgical care of afflicted and crippled children to the fee schedule fixed by the individual county. Example: If a county pays ninety dollars or more for medical or surgical care of a county ward, the State will pay ninety dollars for service to an afflicted or crippled child in that area; however, if a county pays less than ninety dollars, the State will pay the doctors of medicine in that area no more for care of State patients than is allowed by the county. In some counties of Michigan, therefore, the recent favorable amendments to the Crippled-Afflicted Children Laws will have no salutary effect on the doctors who practice in those counties.

The MSMS House of Delegates has urged for several years that all component county and district medical societies, whose rates and schedules for the care of governmental wards are below costs, should make every effort to negotiate necessary revisions in schedules of benefits so that individual members of these societies are not penalized by being forced to perform services at a financial loss and far below the fees indicated in the Uniform Fee Schedule for Governmental Agencies, adopted by the MSMS House of Delegates in September, 1945.

* * *

PRESENTATION OF SPECIAL MEMBERSHIPS

The 1946 MSMS House of Delegates set up the following procedure for presentation of special memberships (Emeritus, Life, Retired, Associate, Honorary) to the House of Delegates annually: Recommendations for special memberships shall be

(Continued on Page 886)

WHENEVER NUTRIENT INTAKE MUST BE AUGMENTED

The occasion frequently arises when the intake of all essential nutrients must be increased, as in general undernutrition, following recovery from infectious diseases and surgical trauma, and during periods of anorexia when food consumption is curtailed.

In the general management of these conditions, the dietary supplement made by mixing Ovaltine with milk can find wide applicability. Delicious in taste, it is enjoyed by all patients, young and old. Its low curd tension and easy digestibility impose no added gastrointestinal burden on the patient. This nutritious food drink supplies all the nutrients considered essential for a dietary supplement: biologically adequate protein, readily utilized carbohydrate, easily emulsified fat, B-complex and other vitamins including ascorbic acid, and essential minerals. The recommended three glassfuls daily virtually assures normal nutrient intake when taken in conjunction with even a fair or average diet.

THE WANDER COMPANY, 360 N. MICHIGAN AVE., CHICAGO 1, ILL.

Ovaltine

Three servings daily of Ovaltine, each made of ½ oz. of Ovaltine and 8 oz. of whole milk,* provide:

CALORIES	669	VITAMIN A	3000 I.U.
PROTEIN	32.1 Gm.	VITAMIN B_1	1.16 mg.
FAT	31.5 Gm.	RIBOFLAVIN	2.00 mg.
CARBOHYDRATE	64.8 Gm.	NIACIN	6.8 mg.
CALCIUM	1.12 Gm.	VITAMIN C	30.0 mg.
PHOSPHORUS	0.94 Gm.	VITAMIN D	417 I.U.
IRON	12.0 mg.	COPPER	0.50 mg.

*Based on average reported values for milk.

PRESENTATION OF SPECIAL MEMBERSHIPS

(Continued from Page 884)

presented to the Chairman of the Committee on Special Membership prior to the first meeting of the Annual Session of the House of Delegates for presentation *in toto* by the Committee Chairman to the House. (The first meeting of the 1947 House of Delegates will be held on Sunday, September 21, 1947, at 2:00 p.m., in the Ballroom of the Pantlind Hotel, Grand Rapids). The Secretary of the House of Delegates, L. Fernald Foster, M.D., will collect the resolutions and recommendations and transmit them to the Committee on Special Memberships.

* * *

RAILROAD EMPLOYES' SICKNESS INSURANCE PROGRAM

A cash sickness benefit program for railroad workers began operating throughout the nation on July 1. These benefits were added under the 1946 amendments to the Railroad Unemployment Insurance Act and provide partial compensation for wage loss due to disability on the same basis as that due to unemployment. The system is administered by the Railroad Retirement Board.

Approximately 45,000 railroad employes *in Michigan* will be protected by the sickness insurance program.

An estimated $800,000 in sickness benefits will be paid out *in Michigan* in the year beginning July 1, 1947.

Only doctors of medicine are authorized to complete statements of sickness, required before claims can be paid.

Benefits will be paid to the claimant in cash; the normal physician-patient relationship will not be disturbed.

All disabilities which prevent railroad employes from working, regardless of how or where they occur, are covered under the program.

Detailed information may be secured by writing the District Office of U. S. Railroad Retirement Board, 200 Lawyers Bldg., 139 Cadillac Square, Detroit 26, Michigan.

* * *

PROPOSED AMENDMENTS TO MSMS CONSTITUTION

Presented to 1946 House of Delegates for consideration by the 1947 House of Delegates

1. Re Life Membership:

WHEREAS, Article III, Section 8 of the Constitution of the Michigan State Medical Society, re "Life Members" does not adequately serve the best interests of the Michigan State Medical Society and does not confer upon its members the honor intended; therefore be it

RESOLVED, That Section 8 of Article III, of the Michigan State Medical Society Constitution be deleted.

2. Re Life Membership:

WHEREAS, Section 8 of Article III of the Constitution is originally intended to recognize period of service and membership in the Michigan State Medical Society and

WHEREAS, Section 6 requires fifty years in the practice of medicine regardless of attained age of the individual, and

WHEREAS, Ten years of membership, regardless of age, is a relatively short period of membership, therefore be it

RESOLVED, That Section 8 of Article III be amended to read: "A physician who has attained the age of seventy years or more and maintained an active membership in good standing for twenty-five years or more."

3. Re Emeritus Membership:

Amend Article III, Section 6, as follows:

Emeritus Membership—Any physician who has been in practice fifty years, or has attained the age of seventy years, and who has maintained a membership in good standing for twenty-five years, may, upon written application, and upon recommendation of his county society, and by election in the House of Delegates, become a member emeritus. A member emeritus shall be required to pay annual dues to the State Society not in excess of ten dollars and be relieved of paying all assessments. He shall be entitled to all the benefits and privileges of membership.

Delete Section 8 of Article III, which deals with life membership.

4. Re Life Membership:

Amend Article III, Section 8, as follows:

Life Members—A physician who has attained the age of seventy years or more and maintained an active membership in good standing for twenty-five years or more in the State Society may, upon his signed application, filed in the office of the

(Continued on Page 888)

BARRY

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Say you saw it in the Journal of the Michigan State Medical Society

PROPOSED AMENDMENTS TO MSMS CONSTITUTION

(Continued from Page 886)

State Society, and approved by his County Society at a regular or special meeting thereof, be transferred to the Life Members' Roster by election in the House of Delegates. He shall have the right to vote and hold office but shall pay no dues to the State Society. Requests for transfer shall be accompanied by certification by the Secretary of the State Society as to years of membership in good standing.

* * *

"TELL ME, DOCTOR"

"The Michigan State Medical Society is recognized as one of the most progressive in the nation. The latest step in its effort to bring the doctors and the public closer together is a five-day-a-week radio program on CKLW, Monday through Friday at 9:45 a.m. It's called "Tell Me, Doctor," and features informal chats on the latest doings in medicine."—*The Town Crier* (Mark Beltaire) in *Detroit Free Press,* June 24, 1947.

* * *

RURAL GLEANINGS

For 2,000,476 rural inhabitants of Kentucky in 1946 there were only 939 doctors. Of these physicians, 458 were over sixty years old, and some of them closer to eighty. No young ones were taking the places of those retiring. No new doctors were entering the field.

A campaign in Kentucky has raised $100,000 to provide scholarships for medical students who will pledge to serve a stipulated time in rural areas.

Even if the Roosevelt dream of a chain of small hospitals throughout rural America were realized, this would not in itself guarantee adequate medicine to farm communities. Doctors gather in urban areas not only because of superior medical facilities, but also because they make more money there. So long as the supply remains drastically limited, those who can afford to pay more will get the service.—Editorial, *The Nashville Tennessean,* May 14, 1947.

Many rural communities are experiencing a shortage, both in quantity and quality, of medical assistance. The young men specialize and go to the city. The rural community's health becomes the responsibility of a few old-timers.

We don't have the prescription that will save the family doctor from threatened extinction. Group practice, maybe. But we are sure there is a real need today for the kind of doctor who used to be able to bring an anxious household a feeling of reassurance the moment he came in the door.—Editorial, *The Star,* Elizabethton, Tenn., April 27, 1947.

TONSILLECTOMY AND POLIOMYELITIS

A statistical survey indicates that poliomyelitis is relatively infrequent following tonsillectomy. The study carried out at Manhattan Eye, Ear and Throat Hospital on 11,204 tonsillectomy patients over a seven-year period revealed but four cases of poliomyelitis following tonsillectomy. None were of the bulbar type. The widespread alarm on the part of the public, and shared by doctors in some communities, is unfounded on the basis of our statistics.

There is some evidence of an experimental nature which tends to make one believe that there is a casual relationship. Sabin showed that injection of the virus into the tonsillopharyngeal region of monkeys produced poliomyelitis. In thirteen of the sixteen monkeys thus treated, she found histologic evidence of involvement of the nuclei of the cranial nerves, and concluded from these experiments that the poliomyelitis virus entered and reached the nuclei of the cranial nerves through the peripheral nerves supplying the tonsillopharyngeal area.

Yet when she attempted to produce poliomyelitis in monkeys by painting the virus over the operated areas of recently removed tonsils, she was unable to produce the infection. Two other investigators, Toomey and Krill, removed the tonsils of six monkeys and then flooded the operated regions with 10 per cent virus suspension for five days. Again, these monkeys resisted experimental infection.

Recently, Holtman reported that the effect of summer heat on the body chemistry may increase susceptibility to poliomyelitis. He has shown by experiments on mice that the ones maintained in summer heat temperature began showing symptoms and dying as early as the 5th day after inoculation with poliomyelitis virus, whereas the ones kept in a temperature around 55° F. showed no symptoms until the eleventh or thirteenth day.

To determine the role of tonsillectomy in a casual relationship to acute poliomyelitis, one must also consider the attendant surgical shock and the effects of anesthesia. These factors, regardless of the nature or site of operation, might be sufficient to disturb the equilibrium of host and virus. General anesthetics are capable of producing anoxia of the central nervous system. It has been similarly established that the oxygen requirement of the central nervous system is approximately 30 times that of other tissue of the body. Anesthesia, through the production of anoxia, might in itself be sufficient cause for disturbance of the host-virus relationship and capable of precipitating severe attacks of infantile paralysis.

Owing to the importance of this subject of tonsillectomy and poliomyelitis and since there is a diversity of opinion among physicians, the writer suggests a nationwide survey be carried out by the American Laryngological, Rhinological and Otological Society. He believes that such a survey will show no causal relation between tonsillectomy and poliomyelitis. A favorable report, countrywide in scope, will do much to allay the fears of the public which are now widespread.—Daniel S. Cunning, M.D., New York. Condensed from Annals of Otology, Rhinology, and Laryngology, 55:583-590 (Sept.) 1946, in *Digest of Treatment,* June, 1947.

(Continued on Page 890)

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Each support is individually designed for your patient . . . the proper degree of flexibility or rigidity you prescribe is assured.

Supports for deformities, pregnancy, post-operative, sacro-iliac, lumbo-sacral cases are designed, manufactured and fitted at our convenient location.

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(Continued from Page 888)

DEPENDENTS OF DECEASED VETERANS

The Veterans Administration reports that nearly 879,000 dependents of 557,000 deceased veterans of all wars and peacetime service are receiving compensation and pension checks from the Veterans Administration at the rate of over $32,000,000 a month; 396,000 are dependents of deceased World War II veterans. Of these, all but 3,525 are receiving compensation as the result of service-connected death of the veterans; 363,000 are beneficiaries of deceased World War I veterans. Only 96,000 of these receive benefits resulting from service-connected deaths. The rest are being compensated in cases of veteran deaths which did not result from service in the armed forces. The rolls also include 78,000 dependents of deceased Spanish-American War veterans, 19,000 from the Civil War, 2,345 from the Indian wars, 47 from the Mexican War and nearly 20,000 dependents of veterans who died in peacetime service. Of the dependents 372,000 are widows, 261,000 are children and 246,000 are parents of deceased veterans.—*JAMA*, June 14, 1947.

BLUE SHIELD ADVANCES

On June 1, 1947, Blue Shield took an important step forward. On that date its present program of surgical and obstetric benefits in the hospital was extended to include medical (nonsurgical) benefits in the hospital and surgical and obstetric benefits outside the hospital. At the same time, a new schedule of fees for services rendered to holders of Blue Shield policies became effective.

Undoubtedly the latter will receive the utmost attention and a certain amount of criticism, particularly from those participating physicians who are surgeons. The schedule is the result of careful study and of many time-consuming meetings of the committees appointed to prepare it. The committees were composed of specialists in their various fields, who agreed that Blue Shield fees should not be based on the customary value of a specialist's services but on the ability of individuals and families in the under-income group to pay for such services. Much consideration was given to the relative difficulty of procedures not only within the specialties but also between the specialties, with the result that procedures of comparable difficulty in, for example, opthalmology and urology were assigned similar fees so far as it was possible to do so. At first glance the level of fees may seem low, but when it is remembered that they apply to low-income patients, many of whom were previously medically indigent and to patients who were formerly poor credit risks, their adequacy is more easily visualized. It should also be recognized that the schedule applies on a state-wide basis.

With nearly 600,000 persons covered, Blue Shield is now the second largest and one of the most prosperous medical-care plans in the Nation, and much of its success is attributable to the fact that physician participation, originally in the neighborhood of 50 per cent, has rapidly climbed to its present level of over 90 per cent. The Blue Shield Board of Directors, made up of one-third physicians and two-thirds lay persons, is elected by the Executive Committee of the Council of the Massachusetts Medical Society, and before any rules or regulations affecting medical matters can be implemented they must be approved by the Executive Committee. Furthermore, in each district medical society there is a Blue Shield Professional Service Committee, through which the practicing physician can make his voice heard.

The ultimate success of Blue Shield rests primarily on the degree to which the medical profession, collectively and individually, participates. Because of the overwhelming importance of this venture, every physician who is interested in maintaining the voluntary approach to the problem of the costs of medical care and who is not yet a participant should request that he be supplied with an application form.—Editorial, *The New England Journal of Medicine,* June 12, 1947.

THE REGIONAL BOARDS

An analysis of the membership of the Regional Hospital Boards in England and Wales, prepared by the Secretary for the Association Council, shows that for the 14 Boards 85 B.M.A. nominations were made, of which 27 were accepted; 101 other medical members were appointed, making a total of 128 medical members, or just above one-third of the total membership of the Boards. In other words, there is on each Board an average of nine medical members, two of whom are nominees of the Association. Five of the Boards—Manchester, Liverpool, Wales, East Anglia, and South-east Metropolitan—have only one B.M.A. nominee. The Board which has the highest number of medical members—13—is the North-west Metropolitan; the Board with the lowest number—7—is East Anglia. The total membership of a Board varies from 22 to 32. A number of Branches and Divisions of the Association have sent forward resolutions of protest at the inadequacy of the accepted number of B.M.A. nominations.—*British Medical Journal,* Aug. 2, 1947.

STOP—LOOK—LISTEN

STOP telling the patient there is nothing wrong with him but nerves—Don't say: Go home and forget it.

LOOK for the facts as the patient sees them.

LISTEN attentively to patient's story.

An inappropriate remark by the general physician to the emotionally sick person is more dangerous to the patient than the bad slip of a scalpel in the hands of the surgeon.

Psychoneuroses if promptly and properly treated are as curable as other disorders of health.

Psychoneuroses cannot be feigned or faked any easier than can heart disease, and the psychiatrist and the neurologist can detect that faking as easily as the heart specialist can detect feigning of heart disease.

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American Medical Association Meeting

This year's meeting of the American Medical Association was the centennial year, and every feature emphasized that fact. The House of Delegates convened Monday, June 9, 1947. One of the most important features of the meeting was the Report to the Committee on National Emergency Medical Service just completed by Frank G. Dickinson, Ph.D., Director of the Bureau of Economic Research. During November and December, 1946, 50,681 copies of the Postwar Questionnaire were mailed to former medical officers of the Army, Navy, U. S. Public Health Service and Veterans Administration. Of these, 1,244 were returned for incorrect address, leaving 49,457 physicians queried. 26,168 were returned but 150 were unusable, so the survey covers 26,018 or 53 per cent. 20,001 were from former Army Personnel, 5,727 from the Navy, 30 from former Public Health officers, 60 from those who had served in the Veterans Administration, and 200 from those of mixed service, that is, two or more of the services.

Army and Navy physicians who served in World War II had time on their hands while doctors who remained at home during the war years were overworked.

"Navy doctors were more idle than Army doctors only because they had fewer nonprofessional duties," the report shows. "During combat service they were busy only 71 per cent of their time, gaged by civilian standards, of which 51 per cent was in the performance of professional duties and 20 per cent in the performance of nonprofessional duties."

Army medical officers estimated that under the same conditions they were occupied with professional duties 50 per cent of the time, and 30 per cent with nonprofessional duties. During noncombat periods, navy doctors were busy with professional duties 40 per cent of the time and with nonprofessional duties, 16 per cent; army doctors reported 39 per cent of their noncombat time was occupied with professional duties, 23 per cent nonprofessional.

In contrast to this report, the analysis of 2,322 replies to a questionnaire sent to a random selection of physicians who remained in civilian practice during the war years showed that they had treated 76 per cent more patients in 1944 than in 1941.

Comparisons between Army and Navy doctors revealed that the average Army doctor served 42 months as against 36 months for the average Navy doctor.

The report said in part: "A smaller percentage of Navy doctors, 11, were general practitioners before entering military service than Army doctors, 17; likewise fewer Navy doctors were part-time (18 per cent) and more (33 per cent) were full-time specialists; also more (20.3 per cent) were members of American boards. The replying Navy doctors slightly outranked the replying Army doctors, and slightly more of them spent their entire or longest period of service in North America. A larger percentage (60) Army than Navy spent more time in hospitals than in dispensaries and other types of service.

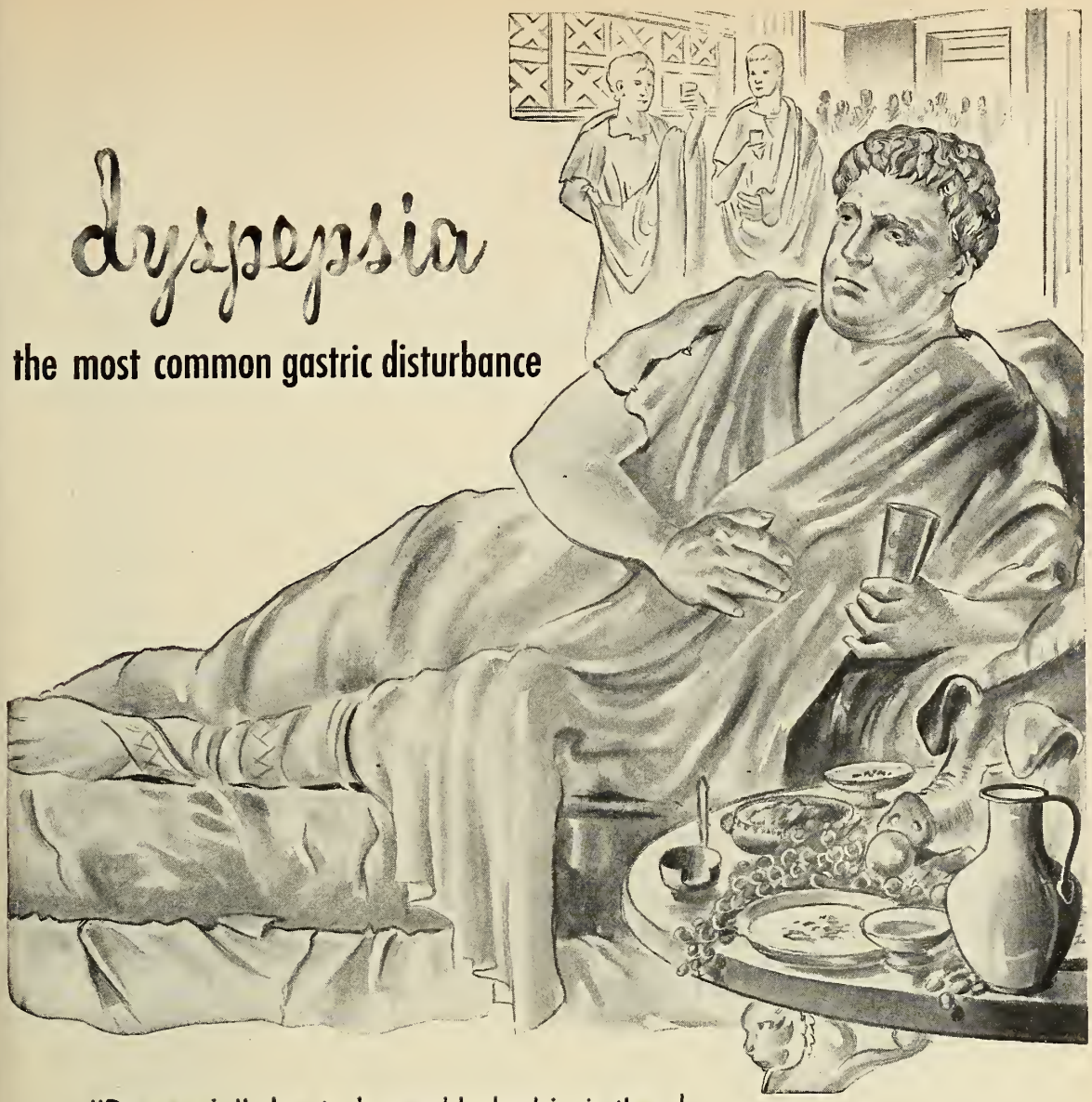
"Doctors were asked to estimate the number of physicians actually needed in their units; Army replies averaged 72 per cent and Navy replies 70 per cent, reflecting consideration of 'peak load' requirements. The general conclusion of the survey is that considerably more doctors were inducted into the armed services than were needed in the opinion of the doctors themselves, although some question may be raised concerning the competence of humble doctors in the ranks to measure military necessity as to both time and nonprofessional duties. Replies from so many doctors give weight to these criticisms—the wastage of medical skills.

"Both Army and Navy doctors agreed that professional 'on-the-job' training was the most useful feature of their training, and that an ideal training program should stress more medical training, both general and in the specialized fields of military medicine. Neither Army nor Navy doctors were enthusiastic about their assignments, although Navy doctors were slightly better satisfied. Forty-eight per cent of the Navy doctors reported that they were rotated in assignment, and only 22 per cent Army doctors. Apparently this difference is not due entirely to the inherent differences between the two branches of the service. A question relating to how medical personnel could have been

(Continued on Page 894)

dyspepsia

the most common gastric disturbance



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(Continued from Page 892)

used more effectively if it was wasted in his unit brought replies which stressed better assignments, reduction in the number of doctors and fewer nonmedical duties, the latter being stressed more by Army than by Navy doctors. Suggestions regarding assignment of medical officers in the event of another national emergency revealed that more consideration of age and qualifications, assignment according to actual need, rotation of duties, and rank and promotion according to professional ability were the most popular remedies. In rating efforts to utilize their professional skills, the replies indicate that the doctors thought these efforts only moderately successful, even less for Army than for Navy. The replies indicated reasonable success in getting medical publications to the doctors, although, of course, Navy doctors had less trouble with transportation and received the journals more regularly. Army doctors reported more teaching clinics and more medical meetings in their theatres than Navy doctors."

In conclusion the report analyzed what the doctors wanted in case of another national emergency.

"What they want must surely be a bold, courageous, forward-looking program and not one which looks backward toward the last war," the report said, adding: "They want a public-spirited organization, representing the profession, established and implemented in the hope that it can help to prevent the mistakes of World War II. They want the limited supply of medical skills carefully and wisely distributed so as to attain the highest standards of medical care for civilians and military personnel in the event of another national emergency. They doubt that 60 per cent of the nation's physicians could provide effective medical care for the civilian population in the event of an atomic war."

"In the second place," the report continued, "the former medical officer wants the highest officials in Washington to ask the Secretary of War and Secretary of Navy to review their organizational tables and procedures in order to prevent a recurrence of (1) the medical overstaffing of units, (2) wasting of the time of doctors of medicine in the performance of nonprofessional duties which could have been performed effectively by nonmedical personnel, (3) removal of a needlessly excessive number of doctors of medicine from civilian hospitals and practices, (4) the rather widespread failure to make assignment and provide for rotation of doctors of medicine on the basis of their professional skills and qualifications, experience and age, (5) a military hospital construction policy which will give close attention to possible civilian wartime requirements."

Major General Raymond W. Bliss, Surgeon General of the Army, was introduced and gave a short talk. He spoke principally on the need of the Army for more high-class doctors for the permanent service. It is now practically impossible to attract doctors, because of the low pay and low rank as regards civilian advantages. A bill is now before congress to increase the rank of medical officers and to also increase the pay. The bill has much opposition during this time of saving on appropriations, but there is some hopes of its passing even though it has been dubbed a salary grab bill. There should be no hesitancy about young men making the army service their life work. The Military has contributed much to the advance of medicine, and has added names to our list of great leaders—Gorgas, Beaumont, Reed, Sternberg, to mention only a few.

Rear Admiral Clifton A. Swanson, Surgeon General of the Navy, was also introduced and in his talk stressed the need for more General Practitioners. He said the best Navy doctor is a good general practitioner with some special training in traumatic surgery. Three to five years of general practice is the fundamental need for building Specialists. The needs of future military medicine will be some methods of overcoming the effects of atomic weapons. The effects of atomic bombs in this war and at Bikini Atol have been minutely studied by both the Army and Navy, and studies are still being made at the Navy base at Bethesda, Md. Admiral Swanson also talked to the Section of Ophthalmology. He has a certificate of both the Ophthalmology and the Otolaryngology boards. He told of the many navy doctors who are now persuing special training leading to specialization and the passing of the American Boards. He said that in World War I, 1.5 per cent of all injuries were eye, but in World War II, 2.5 per cent were eye injuries. That is one reason medical officers, and especially specialists, should be higher rank, because many eye cases were cared for by general surgeons, or general men who did not know the great need for very especial treatment of so many

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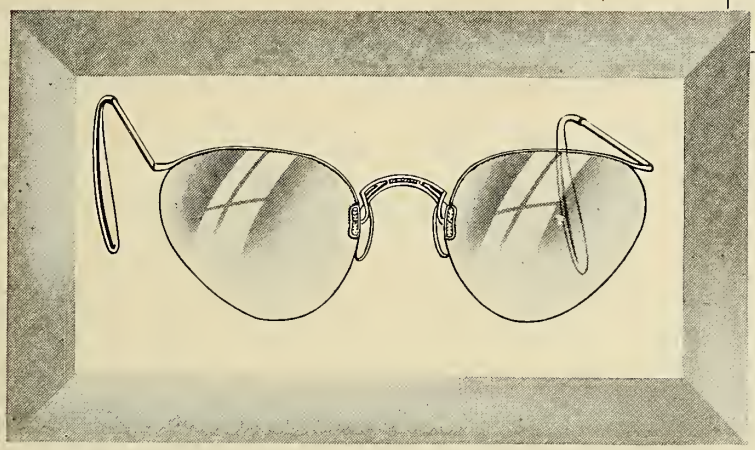

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(Continued from Page 894)

of these eye injuries. He said the Navy lost eighty-three doctors by military action, thirteen by explosions, forty-four from medical causes and twenty-one by miscellaneous accidents.

Noon of the tenth of June after luncheon the Assistant Secretary of the Navy for Air spoke at length upon what he called human engineering. He told of personality studies, of adaptibility of persons to special conditions—that we are asking the human to endure and to overcome conditions of rarefied atmosphere, high pressure, rapid changes and many conditions to which we are not adapted.

Robert Patterson, Secretary of War, also spoke at the noon meeting of the House of Delegates. He said that during the war over 47,000 voluntary medical officers served the Army. They have all been returned to civilian practice except a few who chose to remain, and a small number who were trained in service and still have service duties to perform. The Army is being reduced to 1,300,000 as a choice strength but is actually about a million men of whom half a million are in Germany, Austria, Japan and Korea. The medical strength required for that many men is 6,000, but there are now only about 5,000 doctors in service, giving as of now a shortage of 1,100 doctors. By 1949 there will be a shortage of 3,700, and by 1950, 4,000, unless some effective means is found to recruit doctors in the military service. These efforts have been disappointing, and especially in face of the fact that all other branches of Army special services are overstaffed.

Secretary Patterson spoke of the bill before Congress (H.B. 3174—S. 1143) which will offer a new table of ranks, $100 per month extra pay, 25 per cent extra for approved specialists, and four civilian professorships for the Army Medical School.

Invited guests from foreign countries were presented. Many of them made short speeches, and presented tokens, medals, scrolls, historic documents and manuscripts. These will all be suitably housed at the Headquarters at Chicago.

Admiral Joel T. Boone, who conducted the survey of the bituminous coal miners health matters, gave a good talk, reporting much of the work done by his committee, and made some recommendations. He said he told John L. Lewis that he should hire some very outstanding doctor on a retainer fee just as he does a lawyer, and pay him the same —then he should take the advice given. He said that health and medical welfare are just as important, if not more so, than the financial returns, and just as much care should be given to the study of those problems.

The survey gives a fair appraisal of the medical situation in the soft coal area. The findings in reference to housing, sanitation and recreational facilities would have their counterpart if a cross section of living conditions were studied in almost any part of United States. It is of especial interest to note that the prepayment plan of providing medical care in coal-mining areas is not considered inherently bad by the survey group. In many places this system has resulted in excellent quality of medical service. Failure in other instances has been due to the human element, particularly the three groups especially concerned. This report serves to direct attention to existing deficiencies and is a challenge to the physicians of this country. Because of the technical nature of many of the problems involved, good medical leadership is necessary to correct these deficiencies. The shortage of physicians and other skilled personnel, together with the need for expanded physical plants, makes the present solution of some of these problems difficult. They can be solved eventually, however, by friendly co-operation between the miners, the operators and the physicians. Wherever possible, medical service for the miners should be integrated with that of the community.

Admiral Joel T. Boone, thus summarizes his observations:

> "The report presents convincing evidence that the serious problem of improving the health of the miner, assuring him of better living conditions, enabling him to provide for his family through his own initiative and efforts, and making him a more responsive and responsible citizen of his community is a solvable problem IF labor, management and the medical profession co-operate and work conjointly with a united interest and sincere devotion to a common cause—the good of large numbers of people and a basic industry. Health is a common concern of all groups. Working together for its promotion can help immeasurably to weld the bonds of human interrelationship."

The total attendance had not been announced when the delegates returned from Atlantic City. In fact the last such tabulation seen was Wednesday evening, with two more days to go. At that

(Continued on Page 898)

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The following members of our Michigan field organization will be attending:

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GENERAL ELECTRIC X-RAY CORPORATION

Say you saw it in the Journal of the Michigan State Medical Society

(Continued from Page 896)

time 13,608 doctors had been registered. This was in addition to guests and exhibitors. It was by far the largest attendance ever recorded.

Actions Taken in Atlantic City

The new officers of the American Medical Association who assumed office in Atlantic City are:

Edward L. Bortz, M.D., Philadelphia, Pa., President

Roscoe L. Sensenich, M.D., South Bend, Indiana, President-Elect

Thomas A. McGoldrick, M.D., Brooklyn, N. Y., Vice President

George F. Lull, M.D., Chicago, re-elected Secretary and General Manager

Josiah J. Moore, M.D., Chicago, re-elected Treasurer

R. W. Fouts, M.D., Omaha, Nebraska, re-elected Speaker of the House

Francis F. Borzell, M.D., Philadelphia, Vice Speaker of the House

Dwight H. Murray, M.D., Napa, Calif., re-elected to a five-year term, Board of Trustees.

Edward J. McCormick, M.D., Toledo, Ohio, elected to serve a five-year term, Board of Trustees

Also:

Lloyd Noland, M.D., Fairfield, Ala., re-elected as a member of the Judicial Council

John H. Musser, M.D., New Orleans, re-elected as a member of the Council on Medical Education and Hospitals

William Middleton, M.D., Madison, Wis., elected member of the Council on Medical Education and Hospitals

Stanley P. Reimann, M.D., Philadelphia, and L. B. Jackson, San Antonio, elected to the Council on Scientific Assembly

James R. McVay, M.D., Kansas City, Mo., re-elected a member of the Council on Medical Service, and

Elmer Hess, M.D., Erie, Pa., and Jesse D. Hamer, Phoenix, Ariz., elected to the same council.

The House of Delegates selected Chicago as the 1948 convention city; Atlantic City for the session in 1949 and San Francisco in 1950.

Important among the resolutions adopted by the House of Delegates was the one discharging the Committee on National Emergency Medical Service and constituting this body as a council of the Board of Trustees, to be known as the Council on National Emergency Medical Service. This is a real progressive step, and the work of this group will go forward toward planning for medical care of civilians and military personnel in the event of a national emergency.

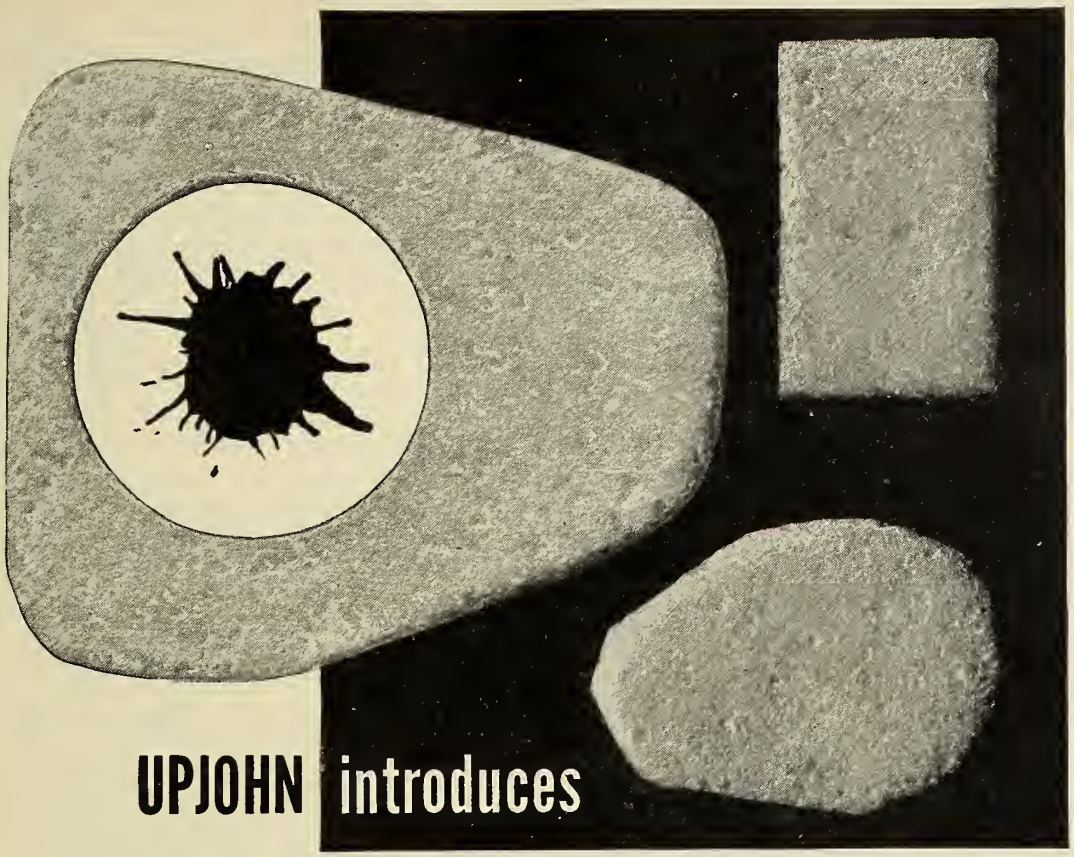
Adopted *in toto* were the recommendations made by President Edward L. Bortz, as follows:

1. A two-day scientific session for general practitioners at the time of the semi-annual meeting of the House of Delegates.
2. Change of meeting place for the semi-annual session—to convene in a different geographic district each year—at which time the two-day session for general practitioners would be held.
3. Closer affiliation with third- and fourth-year medical students—possibly by affiliate membership—and re-establishment of a student section in the JOURNAL, and encouragement of presentation of scientific papers at county, state and national levels; also to study the possibility of a student section of the scientific assembly.
4. The Secretary, in collaboration with the councils and bureaus, to prepare an attractively illustrated booklet describing the various activities carried on by the Association for distribution to graduating medical classes.
5. Further clarification of public relations activities of the Association.
6. More experienced representatives as speakers for lay groups and legislative bodies, and the establishment of a speakers' bureau to assist those representatives.
7. Greater utilization of the Woman's Auxiliary as an instrument in the field of public relations.
8. Establishment by the House of Delegates of a Committee on Nursing Problems.
9. Better channeling of information to the House of Delegates of the activities of departments, bureaus and councils.
10. Active co-operation by the Association with governmental officials to work out a program for prompt medical service in case of another national emergency. (See new Council National Emergency Medical Service above.)
11. The House of Delegates to take under advisement a future building program for the Association headquarters.

The Council on Medical Education and Hospitals adopted new standards for residencies and fellowships in the specialties. These will appear in the proceedings of the House to be published in the THE JOURNAL, and will also be reprinted and distributed.

The National Conference of County Medical Society Officers billed as a "Grass Roots Conference," held its initial meeting in Atlantic City and was unanimously voted continuance. This action was approved by the House. Future meetings will be held for the purpose of developing a working partnership between the AMA and every physician.

The Atlantic City registration totaled 15,667 doctors of medicine, making the Centennial Session the greatest medical meeting ever held anywhere in the world.



UPJOHN introduces

a new advance in the control of bleeding

The development of Gelfoam* by the Upjohn research laboratories marks a new advance in hemostasis. Gelfoam is a readily absorbable, easily cut and molded gelatin sponge which may be used with or without thrombin and may be left in situ without fear of tissue reactions. Gelfoam makes readily available biochemical hemostasis to simplify the clearing of oozing surfaces, the control of capillary bleeding, the arrest of trickling from small veins, and the staunching of annoying hemorrhage from resected tissues. It has a wide variety of indications in surgery and general practice. Gelfoam is a unique addition to the surgical armamentarium for the control of bleeding.

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Gelfoam

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is made in sponges 20 x 60 x 7 mm. in size. Four sponges are packed in each jar.

Third Annual Conference of Presidents and Other Officers of State Medical Associations

The Third Annual Conference of Presidents and Other Officers of State Medical Associations was held Sunday, June 8, 1947, at the Ritz-Carlton Hotel in Atlantic City, New Jersey. This is the organization growing out of the conference called by Andrew S. Brunk, M.D., while President of the Michigan State Medical Society, to formulate some postive plan that the medical profession could endorse, and which would give the public some needed program for extension of medical services to all who need them, but in an American manner, not through compulsion. The first two meetings were held in Chicago, December, 1945, and in San Francisco, July, 1946.

The program for 1947 was:

"The Medical Profession's Program to Improve Medical Care."—L. Howard Schriver, M.D., Cincinnati, Ohio, President-elect, Conference of Presidents; Past-President, Ohio State Medical Association; President, Associated Medical Care Plans, Inc.

"Co-operation of the Medical Profession with the Veterans Administration."—Major General Paul R. Hawley, Washington, D. C.; United States Army, Retired; Chief Medical Director, Veterans Administration.

"Health Legislation in Congress."—The Honorable Robert A. Taft, Washington, D. C., United States Senator from Ohio.

In the course of his address, Dr. Schriver said there are now sixty-three medical service plans in the United States, thirty-two of which are primarily service plans, and thirty-one primarily indemnity plans. Many of course, step over the border and are not purely one or the other. Blue Cross medical plans are in operation in thirty-eight states, and are being formed in most of the others. These plans have proven highly economical, the average cost of operation being 13.7 per cent.

General Paul R. Hawley told of the home town care for veterans. He also told of increased plans for care by the bureau direct, the government using civilian doctors for much service not now readily available in the Veterans Hospitals. About one out of seventy persons are veterans receiving care from the department, and they are costing about $213.00 per year per patient. This is more than the average patient in the United States and more than the amount planned for the Bureau—— $21,000,000 is now being paid to doctors for services to veterans.

General Hawley mentioned the two bills for public care, and seemed to think there was no great difference in them; either would work with satisfaction. Medical care has two great approaches: independent and untrammeled services, or federal planning. The great problem is federal expenses. Three and a half billions are being used for veterans' services. The general said that more patients are now being discharged from veterans' hospitals than are being admitted.

Senator Robert A. Taft said that the American people for twenty-five years have enjoyed the finest medical care in the world. Shall we improve our present free system, or reject it and change to a federal bureau? There is a real and significant difference in the two approaches to federal medical service. The Wagner-Murray-Dingell Bill has been rewritten but not much changed. It is an income tax on the lower income. It does not levy a tax, but provides for an appropriation of 3 per cent and 1 per cent on incomes up to $3,600 a year. Laborers will pay up to $144 per year. No one knows what the cost will be, but the money goes into a Washington Bureau. A tremendous bureaucracy of from one quarter to three quarters of a million persons, will develop, to run it and determine for the government who shall have what doctor when. The bill says there will be state administrators, but they are appointed and are under a federal bureau. Federal activity will take over and may make this bureau as inefficient as the old WPA.

Senator Murray is worried about the means test in the Taft Bill. He needn't. We now have the means to test for all relief and indigent care, and these are the only ones who will come under federal care (and that will be state administered) under the Taft Bill. Means test is the bogey, but all taxes are a means test. All doctors' services are now based on a means test—the doctor has to determine what to charge, or whether to charge. The W-M-D Bill is a tax, and not insurance, as

(Continued on Page 938)

The subject is: Allergy

The advice, as usual, is: "SEE YOUR DOCTOR"

In LIFE and other national magazines, Parke-Davis presents a timely message about allergy (shown below). It appears in full color . . . reaches an audience of nearly 23 million people. It is No. 206 in the "See Your Doctor" series published in behalf of the medical profession.

Some things you should know about allergy

No. 206 in a series of messages from Parke, Davis & Co. on the importance of prompt and proper medical care.

MEDICAL science has discovered many interesting things about allergy.

If today you tell your doctor that you suffer from asthma, sneezing attacks, or itching eyes, one thing he considers is the possibility that you may be *allergic*—which means that you may be sensitive to some substance which causes no trouble for most people.

In discovering this offending substance (known as an allergen), your doctor acts as a detective. He may ask detailed questions about the time of your attacks, where they occur, the furnishings of your home, the food you eat.

Such questions may give him clues to the nature of your trouble. If your attacks come, for instance, in the late spring or summer months and last till the first frosts, he will suspect that your trouble is due to some pollen, that you may have some form of "hay fever."

In other forms of allergy, it is not so easy to track down the offending substance. If your case is not clear-cut, your doctor must consider hundreds of possibilities.

A few grains of mustard can make some people violently ill. A man can be sensitive to his wife's face powder, or to dog hair, or grass pollen, or to the cattle hair in the mat under a rug.

Simple skin tests are often used to reveal the offending substance. Drops of various extracts—of pollen, foods, and other substances—are injected into the skin or put on skin scratches. If you are sensitive to the substance being tested, a swelling will usually develop within a few minutes.

Once a doctor has found what causes the allergic reaction—by means of the history of the case supplemented by skin tests—he will prescribe treatment according to the nature of the patient's sensitivities.

If the patient is allergic to a particular food, the easiest solution is to avoid the food. If his sensitivity is to feathers, the substitution of a fibre pillow for a feather one may bring surprisingly effective relief.

If the allergen is house dust or pollen, or something else that cannot be easily avoided, a series of inoculations may be suggested.

Some people, however, do not respond to this type of treatment, or are sensitive to too many different things to make inoculations a practical procedure. New chemical drugs—developed to control allergic reactions in certain types of allergy—are showing promise. They are to be used, of course, only under the direction of a physician.

SEE YOUR DOCTOR. If you suffer from recurring and unexplained attacks of sneezing, skin rashes, or asthma, see your doctor. In allergy, as in other medical problems, your physician can give you more help today than ever before.

Makers of medicines prescribed by physicians

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Hearings Before Senate Committee on S. 545

By Jay C. Ketchum
Executive Vice President, Michigan Medical Service
Detroit, Michigan

This statement is made from the point of view of the administration of the Voluntary Health Care Plan and is limited to an expression of opinion regarding portions of S-545, particularly Section 712(a) and Section 306.

The Voluntary Health Care Plans, such as the so-called Blue Cross and Blue Shield Plan (in Michigan, Michigan Medical Service and Michigan Hospital Service) have demonstrated the feasibility of providing prepayment of budgeting for or insurance against the costs of hospitalization and medical care among families or individuals enjoying more than minimum incomes. There have been rapid advances in technique and methods employed in making such protection available to all classes of the population, resulting in greatly increased numbers covered as well as in a broadening of the types and extent of protection afforded by these plans. Others will undoubtedly testify here with accuracy as to the numbers now covered by such plans throughout the United States, as to the organization of plans in areas not previously served and the nature of the benefits afforded by the various plans throughout the country.

It is obvious that families and individuals in the extreme low income classes have not been included in the protection of these plans except as they may be from time to time employed where such benefits are automatically included as a perquisite in connection with such employment. The plans, being compelled to operate on a sound actuarial basis, without benefit of contribution or subsidy, have been unable to grant to these so-called medically indigent and welfare classes either cut rates or free protection.

Negotiations have been carried on in Michigan with certain County Boards of Supervisors and Welfare Boards with a view to arranging for the protection of the prepayment plans of Michigan Medical Service and Michigan Hospital Service (commonly called the Blue Cross Plans of Michigan) for the medically indigent. Similar negotiations have been carried on by plans in other areas. These negotiations have failed, at least in Michigan, in every case for one or another of several reasons:

(1) Inadequate County Welfare funds to provide for the care required by the welfare load and the medically indigent load. It has been fairly common practice for such units to purchase such care as needed at agreed fee schedules, as long as funds were available, and thereafter to rely on the charity of the individual physician or hospital to provide needed care. This results in the necessity for the physician or the hospital, if he or it is to continue to provide such care, recouping his or its losses in such cases by spreading the cost of service among those able to pay, which is in effect only a form of general taxation. In some areas such care is purchased on an annual lump sum basis, sometimes on a fee basis, through arrangements with County Medical Society groups and local hospitals, sometimes by contract with individual physicians or individual hospitals for the servicing of the entire welfare or indigency loads. In such arrangements there is an unlimited number of variations as to the details and undoubtedly as to the nature of the services rendered—both as to quantity and quality. At best, inadequacy of funds in these cases certainly influences the quantity of medical and hospital care available.

(2) Application of the insurance principle to the problems of the medically indigent, as differentiated from the clearly defined welfare load, appears impossible even though adequate funds may be available, due to the inability of the various governmental units to foresee the needs. Whereas the welfare load is possible of evaluation for any reasonable period of time on an acturial basis, the so-called medically indigent, with income and funds adequate for ordinary needs, becomes a responsibility of government only at the time of an emergency; in this case, a health emergency. It is therefore impossible for the insurance or plan actuary to promulgate a charge for coverage or insurance of this class.

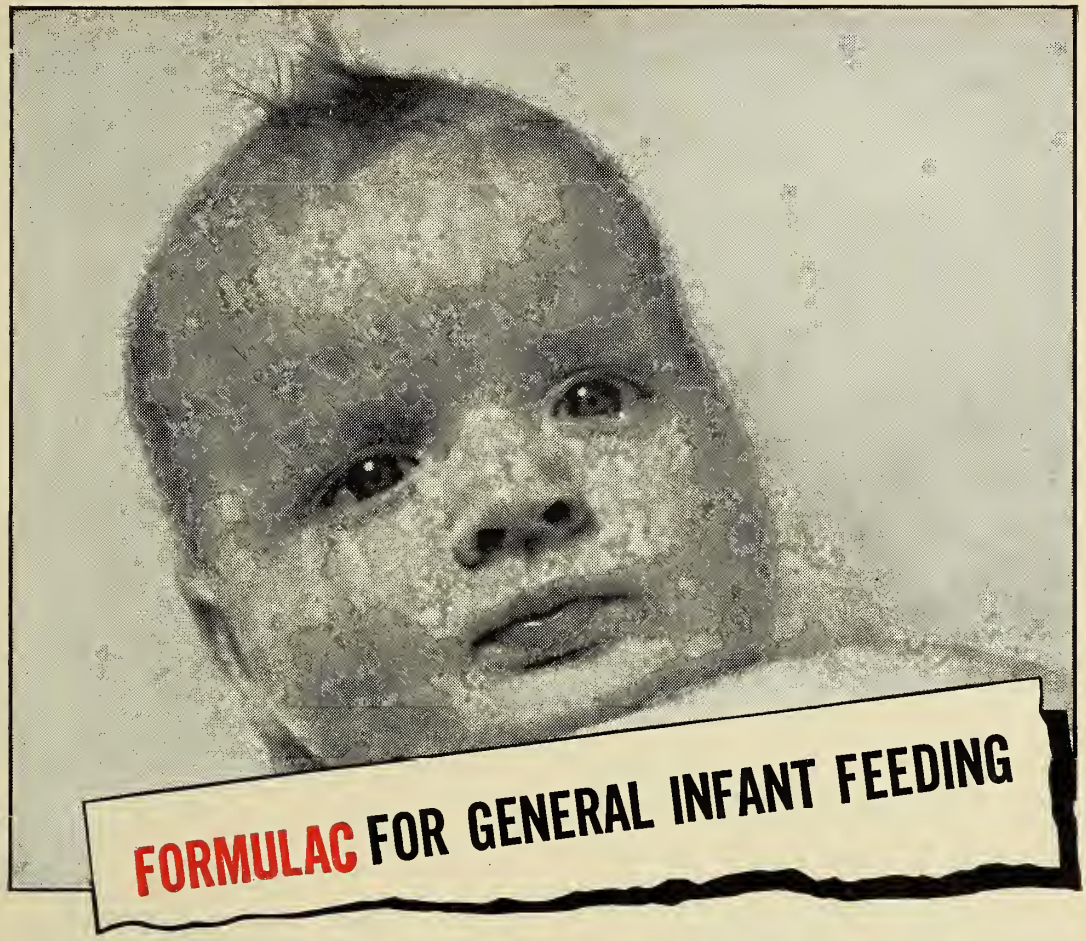
(3) There is in many cases the possibility of assigning the responsibility for care of a welfare or medically indigent to some special fund or statutory health care activity of some other governmental unit, resulting in a reluctance on the part of the local county or welfare board to accept a broad responsibility, in advance of demand, for its people. These conditions arise due to a lack of co-ordination in the planning and operation between various units and departments of government in the various fields of health care as regards specific services or classes of people.

The provisions of S-545, Title VII, appear designed to require 712(a) (7) a survey or inventory of existing health care, medical, surgical and hospital facilities (8) continuing reports and (9) continuing review of operations 712(a) (1) the designation of a single State agency as the sole agency for supervision of administration et cetera.

The provisions of these and other sections should result in integration and co-ordination of all health services within a state and between all units of government in regard to planning for, responsibility for, and provision of health care for all types of cases and all classes of medically indigent.

The financial grants provided for under S-545, if enacted and a state plan adopted thereunder, should

(Continued on Page 904)



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FORMULAC is promoted ethically, to the medical profession only. Clinical testing has proved it satisfactory in promoting normal infant growth and development. On sale in grocery and drug stores throughout the country, FORMULAC is priced within range of even modest incomes.

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(Continued from Page 902)

provide units responsible for such care which comply with the requirements of the Act and the state plan with much more adequate means of providing care which previously may not have been within the financial means of the local unit.

While it is admittedly impossible to apply the insurance principle to the borderline medically indigent, the clearly welfare cases are possible of inclusion under insurance or prepayment plans.

Techniques have been developed to provide service through voluntary health care plans for groups of individuals whose health care is the responsibility of government. Plans have been in operation for some eighteen months or more providing care to veterans in the home, physician's office or hospital, for service-connected disabilities, disability pension determination examinations and emergency care. These arrangements are based on a so-called cost plus operation whereby the health care plan provides the services of its participating physicians and hospitals with free choice for the recipient, at an agreed upon schedule of fees, and costs with an amount added to cover only the overhead expenses of the plan. An example of this type of service is the agreement between the Veterans Administration and Michigan Medical Service, a copy of which is attached, including the agreed upon fee schedule. It should be noted that this arrangement provides for complete free choice of physician by the veteran recipient among those physicians participating in the plan. In Michigan, the acceptance of this arrangement by the profession includes practically all of the practicing physicians rendering the type of care required for such cases. Some 4,300 physicians have signed agreements to render this care in accordance with the plan out of a total of approximately 5;200 physicians licensed in the State, which latter figure includes physicians practicing specialities not called upon in this program, as well as those engaged only in research, teaching and administrative work.

S-545 Section 712(a) (4) permits such cost plus operation in the Veterans Administration program and the provision of medical care to indigents which is not possible to accomplish under any existing welfare statutes or regulations.

Section 306

One of the major difficulties encountered by voluntary health care plans in extending the benefits of their coverage to more people has been the refusal of Federal government departments, bureaus, agencies et cetera, to permit of deduction from payroll the employe's rate, subscription fee or premium to a voluntary nonprofit health insurance fund. The refusal of the government to allow such payroll deduction has rendered extremely difficult satisfactory arrangements for coverage of governmental employes, their wives and dependents. It is difficult to understand the inconsistency of the government as expressed by this attitude when the government itself is the greatest proponent of the practice of payroll deduction in connection with income tax "pay as you go" deductions, defense bond sale deductions et cetera.

Even though enactment of S-545, which would seem of great benefit to the people of the United States, should fail, it is of vital importance to the employes of the government in its various departments, bureaus, agencies et cetera, and the voluntary health care plan movement in the United States that some provision similar to Section 306 of S-545 be enacted during the present session of Congress.

Attached hereto are statements in connection with the operation of the Veterans Administration program under the agreement with Michigan Medical Service in the State of Michigan.

EXHIBIT 1
MICHIGAN MEDICAL SERVICE
AUTHORIZATIONS RECEIVED THROUGH
VETERANS ADMINISTRATION

	MEDICAL			HOSPITAL	
Month	Treatments	Examinations	Total	Hospital	Total
1946					
March	538	1,000	1,538		1,538
April	1,802	3,220	5,022		5,022
May	2,902	1,275	4,177		4,177
June	3,015	1,293	4,308		4,308
July	3,835	5,534	9,369		9,369
August	3,009	1,780	4,789		4,789
September	6,763	1,105	7,868		7,868
October	5,500	1,523	7,023		7,023
November	3,571	2,064	5,635		5,635
December	3,010	1,930	4,940		4,940
1947					
January	5,360	2,893	8,253	593	8,846
February	6,027	1,697	7,724	432	8,156
March	6,452	2,732	9,184	619	9,803
April	5,994	2,371	8,365	689	9,054
May (1-19)	3,075	1,274	4,349	313	4,662
TOTAL	60,853	31,691	92,544	2,646	95,190

Professional Participation
Doctors registered in Wayne.....1,887
Doctors outside of Wayne.....2,386

Total doctors registered in Michigan.....4,273

MICHIGAN MEDICAL SERVICE
Summary of Operations
Veterans Administration Agreement

Inception 3/1/46 to 3/31/47

Services rendered and billed to V.A.....$708,414.35
Expenses billed to V.A. (6.693%).....47,415.03
Total billed.....$755,829.38
Received from V.A.....414,580.88
Balance due to 3/31/47.....$341,248.50

Payments to physicians for Veterans Administration authorized services are made by Michigan Medical Service within an average of sixteen days, billed to Veterans Administration on an average of ten days from receipt of report of service.

Michigan Medical Service secures and maintains participation of physicians in the program with distribution among the various medical specialties as well as geographically throughout the state. Approximately 90 per cent of the available practicing physicians are participating. Michigan Medical Service assumes the responsibility for adequate and accurate reports of services and examinations, and provides necessary personnel in the field to instruct the physician as to completion of required reports and the methods of examinations.

Michigan Medical Service verifies authorization for

(Continued on Page 988)

A REPORT TO THE DOCTORS

MICHIGAN MEDICAL SERVICE

A Statement of Condition

Michigan Medical Service takes pride in presenting this statement as a record of the service you, the Doctors of Michigan, have rendered to the people of your state through your voluntary, non-profit service organization.

Benefits paid Jan. 1 to May 31, 1947 . . . . . $2,757,203.20

Benefits paid Inception to May 31, 1947 . . . $21,503,190.98

Subscribers to Michigan Medical Service 916,416*

*An increase of 75,424 in first five months of 1947

FINANCIAL STATEMENT

May 31, 1947

ASSETS		LIABILITIES AND RESERVES	
Cash in Banks and Office	$ 558,778.95	Reserves for payments for services rendered subscribers (Including Unreported)	$ 746,044.34
United States and Canadian Government Bonds	1,506,395.80	Reserve for Unearned Subscription Fees	385,826.39
Accrued Interest	11,750.00	Reserve for Contingencies	1,434,626.87
Subscription Fees—Receivable	44,188.66	Other Liabilities	25,903.04
Funds Advanced for Veterans Administration	384,175.00		
Other Assets	87,112.23		
Total Assets	$2,592,400.64	Total Liabilities and Reserves	$2,592,400.64

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Contributions and Pledges to Michigan Foundation for Medical and Health Education

September 18, 1945 — August 1, 1947

Allegan County Medical Society	$ 85.
Anonymous	1,000.
Anonymous (Memory of Mother)	1,000.
Regis F. Asselin, M.D., Detroit	5.
R. H. Baribeau, M.D., Battle Creek	50.
Barry County Medical Society	50.
M. G. Becker, M.D., Edmore	1,000.
A. P. Biddle Estate	2,933.81
Branch County Medical Society	85.
C. D. Brooks, M.D., Detroit	1,000.
J. D. Bruce, M.D., Ann Arbor	1,000.
A. S. Brunk, M.D., Detroit	1,000.
Mary Lou Byrd, M.D., Grand Rapids	25.
A. C. Carlson, M.D., Cottonwood, Arizona	500.
E. I. Carr, M.D., Lansing	1,000.
H. R. Carstens, M.D., Philadelphia, Pa.	1,000.
L. G. Christian, M.D., Lansing	100.
R. E. Clark, M.D., Detroit	25.
B. R. Corbus, M.D., Grand Rapids	500.
Clinton County Medical Society	50.
C. V. Costello, M.D., Holland	1,000.
H. H. Cummings, M.D., Ann Arbor	1,000.
A. C. Curtis, M.D., Ann Arbor	15.
J. S. DeTar, M.D.	1,000.
Dickinson-Iron County Medical Society	80.
Eaton County Medical Society	70.
O. O. Fisher, M.D., Detroit	20.
A. C. Furstenberg, M.D., Ann Arbor	1,000.
L. J. Gariepy, M.D., Detroit	1,000.
Genesee County Medical Society	1,000.
Robt. W. Gillman, M.D., Detroit	1,000.
Gratiot-Isabella-Clare County Medical Society	125.
Grand Traverse-Leelanau-Benzie County Medical Society	167.50
T. J. Heldt, M.D., Detroit	25.
Lee Hileman, M.D., Ecorse	10.
Hillsdale County Medical Society	95.
L. J. Hirschman, M.D., Detroit	1,000.
L. E. Holly, M.D., Muskegon	1,000.
Houghton-Baraga-Keweenaw County Medical Society	140.
R. J. Hubbell, M.D., Kalamazoo	1,000.
Huron County Medical Society	55.
Wm. A. Hyland, M.D., Grand Rapids	1,000.
Ingham County Medical Society	1,572.50
S. W. Insley, M.D., Detroit	1,000.
Jackson County Medical Society	350.
Joint Committee on Health Education	1,000.
Francis Jones, M.D., Lansing	1,000.
F. H. Lashmet, M.D., Petosky	100.
Lenawee County Medical Society	125.
S. R. Light, M.D., Kalamazoo	100.
Macomb County Medical Society	130.
Manistee County Medical Society	200.
Marquette-Alger County Medical Society	135.
F. F. McMillan, M.D., Charlevoix	100.
Mason County Medical Society	35.
Mecosto-Osceola-Lake County Medical Society	45.
H. A. Meinke, M.D., Hazel Park	50.
Menominee County Medical Society	10,000.
Michigan Medical Service	10,000.
Mrs. K. B. Miner, Flint	1,000.
Monroe County Medical Society	145.
H. R. Moore, M.D., Newaygo	1,000.
H. L. Morris, M.D., Detroit	1,000.
Muskegon County Medical Society	310.
R. L. Mustard, M.D., Battle Creek	1,000.
Cora Boyce Neal, Grand Rapids	1,000.
Ontonagon County Medical Society	15.
Wm. H. Parks, M.D., Petoskey	100.
A. W. Petersohn, M.D., Battle Creek	25.
L. B. Rasmussen, M.D., Vicksburg	25.
Lawrence Reynolds, M.D., Detroit	1,000.
J. M. Robb, M.D., Detroit	1,000.
J. M. Robb, M.D., Detroit (Memorial to the late J. D. Bruce, M.D.)	100.
John Rodger, M.D., Bellaire	100.
G. B. Saltonstall, M.D., Charlevoix	1,000.
Sanilac County Medical Society	50.
C. A. Scheurer, M.D., Pigeon	30.
E. F. Sladek, M.D., Traverse City	5,000.
Ferris N. Smith, M.D., Grand Rapids	1,000.
St. Clair County Medical Society	220.
Shiawassee County Medical Society	1,000.
H. B. Steinbach, M.D., Detroit	100.
R. H. Stevens, M.D., Detroit	1,000.
C. L. Straith, M.D., Detroit	1,000.
R. H. Strange, M.D., Mt. Pleasant	1,000.
Jerrian VanDellen, M.D., East Jordan	100.
Ralph Wadley, M.D., Lansing	1,000.
R. V. Walker, M.D., Detroit	1,000.
Washtenaw County Medical Society	200.
H. L. Weitz, M.D., Traverse City	100.
C. G. Wencke, M.D., Battle Creek	10.
E. L. Whitney, M.D., Detroit	25.
S. B. Winslow, M.D., Battle Creek	50.
E. R. Witwer, M.D., Detroit	1,000.
Margaret H. Zalen, M.D., Kalamazoo	5.

(Pledge Card on Page 908)

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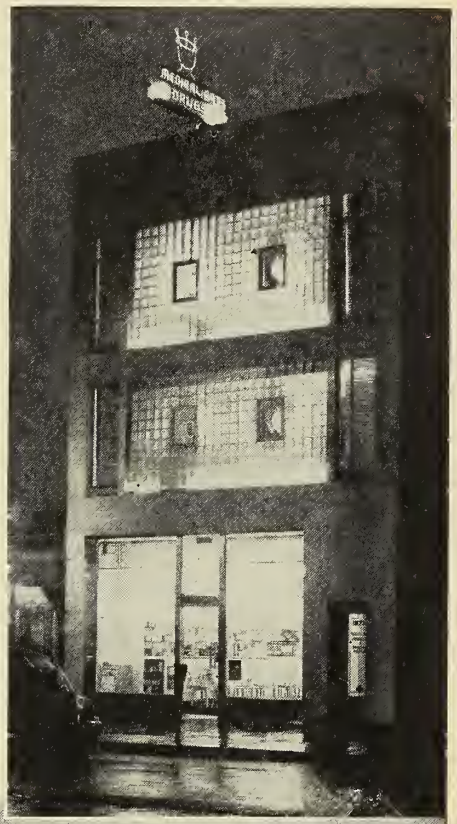

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For the Good of Michigan

The Michigan Legislature has passed three bills during its recent session which add to the framework of the Commonwealth and reveal that the elected representatives of the people have the best interests of the people at heart. They may have, as everyone has, trouble balancing the budget, but they know what they want for their children and their children's children.

It is now mandatory that all who attend school be immunized against diphtheria, whooping cough and smallpox as a condition precedent to entrance in school. These epidemic diseases need not devastate our future citizens, and they will not, thanks to the foresight of the 1947 Legislature. Thank them! I imagine there will be protests by vegetarians who will say that the biological immunizing products are derived from animals, but this is picayune and the courts can handle that.

The availability of animals other than the human for research in the cause and cure of human ills is preserved by the 1947 Legislature despite the bitter activity of a group of zealots who have never been known to refuse a sirloin steak or a lamb chop or a soft boiled egg (whose loss, incidentally, to the steer, the wooly lamb or the plymouth rock must be as real!) The Legislators weren't fooled by the pressure of an absentee-owned press, either. Thank them!

The broad provisions of the Federal Hospital Survey and Construction Act may now be applied in Michigan without partisan or cult-inspired restriction: so that if and when Federal funds flow for the construction of needed hospital beds, thank your 1947 Legislature for augmenting progress instead of impeding it.

I wish there were space to go over the roster of Legislators who have shown that they are in fact citizens of Michigan. It is of note that the first term representatives have shown an understanding of the needs of Michigan far beyond their length of service in the state capitol. The people of Michigan can be proud of this.

William Bromme, M.D.

Associate Editor, in *Detroit Medical News* (WCMS), June 23, 1947

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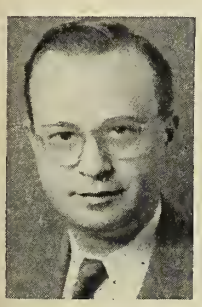
Skin Grafting for Recurrent Pilonidal Cyst

A Method of Primary Wound Closure Following Surgical Excision

By James W. Hubly, M.D., Russell L. Mustard, M.D., and Richard A. Stiefel, M.D.
Battle Creek, Michigan



James W. Hubly

The patient who presents himself with a complaint of recurrence following several operations for pilonidal cyst is a problem in surgical management quite different from the problem presented before the original operation. Examination of the sacrococcygeal area usually reveals a hypertrophic scar with areas of indolent granulation and one or more sinuses producing a purulent discharge. Because of the soft tissue lost at each operation there often is "bridging" of the scar. The scar is on tension due to the pull of the buttocks. When such a scar, along with its sinuses, is excised and the soft tissue allowed to retract to its normal position, a gaping wound will exist.

The problem then becomes one of wound closure. It is not our desire to discuss the various methods of wound closure possible in this circumstance. We wish only to call attention to the use of the split-skin graft for this purpose. Although grafting may be used after primary excision, we reserve it for secondary operations, particularly if considerable soft tissue has been lost at previous operations.

The operative technique we have employed is as follows:

Preoperative preparation: An enema is given the night before the day of operation. It is desirable to have the lower rectum empty. The skin of the operative site is cleansed and shaved. Nembutal and morphine and scopolamine are used for sedation.

Anesthesia: Spinal anesthesia.

Position: The patient is placed prone with the buttocks slightly elevated. Exposure is facilitated by placing adhesive plaster strips under some tension from buttocks to table.

Operative preparation: Tincture of zepherin is used for skin sterilization. The operative site is doubly draped so that one buttock alone, preferably the right, is exposed. This permits the skin graft to be taken from the buttocks without contamination from the pilonidal area.

Operative procedure: The area of skin graft required is estimated, being usually somewhat less than the full width of the Padgett dermatome drum and about one half its length. The Padgett dermatome is set to cut a graft between 0.015 and 0.020 inches in thickness. The cement is applied to the drum and donor site and allowed to dry for several minutes. When sufficiently dry the drum is applied to the donor site, and by rotating the drum the graft is cut, using a full easy stroke of the blade. The graft is left upon the drum and covered with gauze moistened in physiologic saline solution. The donor site is protected by inverting an emesis basin or similar vessel over it, the vessel being held in place by a towel and clips placed through the towel at the

vessel's circumference. This allows clotting to occur and prevents contamination of the site.

The drapes are now moved to expose the pilonidal area (Fig. 1). A probe may be introduced into the various sinuses to determine their extent. A somewhat oval incision about the old scar is made. The incision is carried down, exposing the sacrococcygeal ligament above. The dissection is carried from above down, excising the involved tissue, the sidewalls of the wound being saucerized and not undermined. Following excision, complete hemostasis is obtained, using fine white silk ligature. Mosquito hemostatic forceps are used to clamp bleeding points, care being taken to include only a small amount of tissue in the bite. Annoying capillary oozing can be controlled by the topical application of thrombin solution. Cleansing of the wound, using white soap and water, and irrigation with physiologic saline solution, is done if there has been gross soiling.

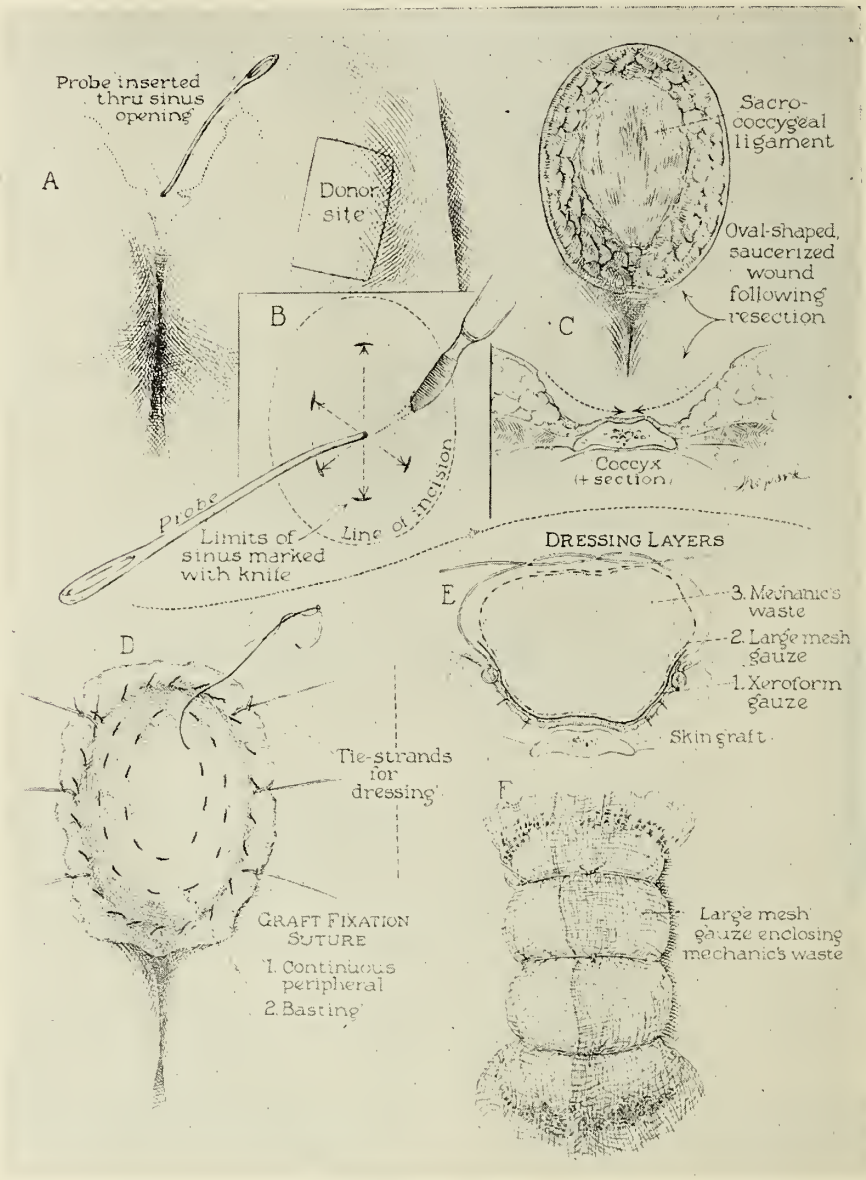


Fig. 1. Operative procedure.

The defect following excision can be lessened by placing a mattress suture at the upper and

lower angles of the wound, approximating the skin edge of the wound to the sacrococcygeal ligament.

The skin graft is now removed from the dermatome drum, and the glued surface dusted with sulfanilamide powder. Sulfanilamide is used not for its chemotherapeutic effect, but because it is conveniently at hand and acts satisfactorily as a powder, thus neutralizing the annoying adhesive properties of the cement adherent to the graft. The graft is placed over the wound, overlapping the skin margins, and under some tension is sutured in place with several interrupted silk sutures. A continuous running silk suture overlapping the graft is then placed, anchoring the graft to the circumference of the wound. It is best to pass the suture needle through graft and then skin. Basting silk sutures are now used to hold the graft down into the depth of the wound. Three silk tie sutures are placed at the wound margin on either side. A bolus is constructed to fit the wound concavity snugly. Mechanic's waste is used, being covered with a layer of large mesh gauze and a layer of xeroform ointment fine mesh gauze. The adhesive strips to the buttocks are released. The bolus is held in place by tying the circumferentially placed sutures under gentle tension. A plain gauze strip is wound around the periphery of the bolus and a pressure pad made of mechanic's waste enclosed in wide mesh gauze is placed over all. The donor site is exposed, blotted with a sterile towel, covered with xeroform ointment gauze, plain gauze squares, and a pressure pad. The wound and donor site dressings are held in place by a stockinette or elastic bandage snugly applied, encircling the body and anchored by passage between the thighs.

Postoperative care: The patient is kept at bed rest. A liquid diet is given for five days. Movement of the bowels is discouraged. Penicillin is administered as prophylaxis against infection. The dressing is examined daily but not removed. If it becomes loosened it is tightened, or reinforced by adhesive strapping. Any evidence of drainage or odor is an indication for redressing. Ordinarily the first dressing is made on the eighth postoperative day. The bolus is removed. The sutures are not disturbed. The graft is cleansed with hydrogen peroxide, dried, covered with xeroform ointment gauze, and a dressing under gentle pressure reapplied. After the first dressing, the wound is dressed daily. The sutures are removed on the 10th postoperative day. Pressure dressings are continued as long as necessary. Usually they can be discontinued after the fourteenth post-operative day, at which time the dressing

Fig. 2. Photograph made twenty-one days after excising of recurrent pilonidal cyst and primary wound closure by skin grafting. The graft was a 100 per cent take.

is removed from the donor site. A daily shower bath may be taken. No sitz baths are used. The postoperative care of the wound is important (Fig. 2).

Comment

We would like to emphasize the relative simplicity of the procedure described. It will succeed when other more complicated methods of closure will fail. One must, however, adhere to the principles governing all skin grafting, namely asepsis, meticulous hemostasis, the gentle handling of tissue, and the proper application of pressure. "Piecrusting" the graft to permit drainage is unnecessary if hemostasis has been complete. If it is done granulations grow up through the small incisions and delay healing. If a portion of the graft fails to take, the area usually will heal quite rapidly by second intention and no draining sinus will persist. We have had no trouble with the donor sites. They have healed uniformly well, healing being complete in ten to fourteen days. The amount of residual deformity at the wound site varies considerably. Ordinarily the original operative defect is lessened between 30 and 50 per cent as a result of contracture. Although the graft is sutured directly down upon the sacrococcygeal ligament, no patient has complained of tenderness or discomfort in the region.

Trends in Diabetes Mellitus

By George C. Thosteson, M.D.
Detroit, Michigan

Of the common chronic diseases we treat, it is interesting to reflect that diabetes mellitus is one of the very few for which we have as specific a therapeutic agent as insulin. The clinician treating diabetes is constantly watching the work of the research physiologist and biochemist, hoping to find another piece to add to that jig-saw puzzle called diabetes mellitus. But even with this most effective weapon, insulin, as a big piece of the puzzle, the picture will not be complete without finding other pieces, such as cause, prevention, and the many secondary factors contributing to the disease.

In this communication, an attempt is made to correlate, in an indirect way, a few of the laboratory findings, particularly the more recent ones, that have contributed to our present-day concept of diabetes mellitus.

The pancreas has been the target organ in the body since 1788 when Cawley found abnormal changes in this structure in a fatal case of diabetes. Impetus in this direction was added when Von Mering and Minkowski produced diabetes in a dog by pancreatectomy in 1889. This was a purely accidental finding in that their studies were directed toward the digestive enzymes of the pancreas. Experimental diabetes was thereafter produced in animals by pancreatectomy. Logical follow-up in this direction for a specific agent within this gland led Banting and Best to their epoch-making discovery of insulin twenty-five years ago when they successfully produced a pancreatic extract with effective hypoglycemic properties.

One would expect that the pancreas should show pathological changes in the diabetic, but this is not always the case. In Warren's[22] series 25 per cent showed no changes; the remainder had a variety of changes, as fibrosis of the beta cells, hyalinization of the islets, and hydropic degeneration. Gellerstedt[7] found many of these lesions in older people, only a few of whom had diabetes.

Gomori[9] has shown that the normal pancreas has an average of 500,000 islets. The structure of the islet is composed of 60 to 90 per cent beta cells, 2 to 8 per cent delta cells, and the remainder alpha cells. His effort to show an abnormal ratio of beta to alpha cells in diabetes mellitus was disappointing since only a few showed a low number or absence of beta cells while the majority were normal. He points out that the beta cells may be well preserved even in greatly shrunken hyalinized islets.

No pancreatic lesion has been found peculiar to diabetes mellitus. Warren and Root[23] point out that whatever the cause of diabetes may be, it seemingly acts over a long period of time, perhaps throughout the duration of the disease, and that pathologic changes found at autopsy only represent the end result of the long struggle between the regenerative activity of the pancreas and the degenerative changes caused by diabetogenic factors. The process is not static, and they state that transient injury to the islets may explain severe loss of tolerance in the diabetic during infections, while improvement in tolerance may well represent rapid regeneration of the islets. A downhill course of the disease represents presumably a losing battle of the regenerative forces.

We must look, therefore, to the functional side of the picture. Here again inconsistencies prevail. Scott and Fischer[19] found the non-diabetic human pancreas to contain an average of 1.7 units of insulin per gram, while that of a severe diabetic contained 1.9 units per gram. The normal individual produces approximately 30 units of insulin a day, yet many of our diabetics require two to three times this amount for control.

Haist and Best[11] in 1940 produced hydropic degeneration in the islets by the injection of anterior pituitary extract and obtained a reduction in the insulin content of the pancreas. When insulin and anterior pituitary extract were used, this reduction did not occur. The feeding of fat did not cause a drop in insulin content. Fasting, fat feeding, and insulin administration prevented fall of insulin content and degenerative changes in the anterior pituitary treated dogs. They thought that these procedures rested the pancreatic islets. The feeding of sugar or a balanced diet immediately raised the insulin content of the gland. Allen had previously shown that the hydropic degeneration of the beta cells occurring in partially depancreatized dogs was followed by atrophy. This was attributed to an exhaustion phenomenon. He did not have insulin to work with at

From the Department of Medicine, Harper Hospital, Detroit, and Wayne University College of Medicine. Presented before The Detroit Dietetic Association, October 9, 1946, and Harper Hospital Staff Meeting, November 8, 1946.

that time. This overwork concept was confirmed by Copp and Barclay[5] when insulin became available. This principle was apparently the reason why the low calorie feedings of Frederick Allen in the pre-insulin days were effective in ameliorating the disease. Haist and Best suggest that their findings constitute a preventive measure in diabetes. They point out that the relative rarity of diabetes among the poor in certain countries where the diet is high in carbohydrate and the prevalence of diabetes among the rich, eating a higher proportion of fat, may be explained by the low caloric intake in the poor man's diet. They produced figures to show that reduction of calories, using a diet containing 50 per cent carbohydrate, resulted in a decrease in the insulin content of the rats studied. The caloric intake therefore is an important factor when considering the dietary effect on the insulin content of the pancreas. Substantiating this is the fact that the fatty livers found in diabetic children can be reduced in size by the reduction in calories and adequate control of the diabetes.

Experimental Diabetes

There are three ways of producing experimental diabetes. The surgical approach by pancreatectomy was suggested by the work of VonMering and Minkowski. Four-fifths to nine-tenths of the pancreas must be removed to produce diabetes in the animal. Another method is the use of extracts of the anterior pituitary gland. This developed after the striking experiment of Houssay of Argentina wherein he found that the diabetes occurring in a depancreatized animal was alleviated by hypophysectomy. Repeated small injections of pituitary extract would keep the animal in a diabetic state and recovery would occur if the injections were stopped. Prolonged large doses, however, will produce a permanent diabetes. This substantiates the findings of Warren and Root, mentioned before, namely, that regeneration of the pancreas tends to occur if the diabetogenic stimulus is not too great or prolonged. Changes produced in the pancreas by this method consist of initial hyperplasia of the islets followed by degranulation, vacuolation, and ultimate disappearance of the beta cells with fibrosis of the islets as the end stages (Gomori).

More recently, in 1943, a chemical method for the production of diabetes was reported by Dunn, Sheehan, and McLetchie.[6] They showed that alloxan, an oxidation product of uric acid, had a selective necrosing effect on the islet cells in appropriate doses. Alloxan has no role in human physiological processes and it disappears very rapidly from the blood stream of the injected animal. The blood sugar curve of alloxan treated animals has a characteristic pattern: there is an initial rise occurring in the first three hours followed by a sharp drop to convulsive hypoglycemic levels after three hours, during which the animal has to be maintained by glucose administration; this then is followed by a permanent elevation of the curve into hyperglycemic zones. The beta cells destroyed by this substance are ultimately replaced by alpha cells.

Influence of Other Endocrine Glands

Wherein does this difference between experimental and human diabetes occur? The role of the endocrine glands and the liver may provide the answer.

The state of the thyroid gland has long been known to influence sugar tolerance. In hyperthyroid states, glycosuria and hyperglycemia occur, whereas hypothyroid states are associated with increased sugar tolerances. One of the key factors in this respect is the influence of the thyroid state upon the rate of absorption of hexoses from the intestinal tract. Althausen[1] showed this rate to be decreased in hypothyroidism and to be increased in hyperthyroidism. This phenomenon vitiates the value of the oral glucose tolerance test and is surmounted by the intravenous test. The role of vitamin B complex in carbohydrate metabolism enters in part in the influence this substance has on the glycogen depleting properties of thyroid substance on the liver. Thyroidectomy will ameliorate human diabetes in many instances when this disease is complicated by thyrotoxicosis. Repeated injection of thyroxin will produce a permanent diabetes in partially depancreatized dogs resulting in what is called a meta-thyroid diabetes.

The adrenal cortex secretions also influence sugar tolerance. Addison's disease is associated with insulin sensitivity and as increased sugar tolerance. On the other hand, the removal of adrenal gland tumors has resulted in the disappearance of diabetic symptoms.

The pituitary gland is often referred to as the master gland of the entire endocrine system. The work of Houssay on the effect of hypophysec-

tomized-depancreatized dogs is classical. The production of anterior pituitary extract diabetes has been referred to, and the increased sugar tolerance and the insulin sensitivity in Simmond's disease is well known. The diabetogenic factor of the pituitary has been isolated. The effect of anterior pituitary extracts in repeated small and large doses has been mentioned above. The hyperglycemic effect of these extracts is not brought about through the adrenal according to Houssay since it occurs after adrenalectomy.

The Liver

The role of the liver in carbohydrate metabolism is most involved. Removal of the liver in depancreatized dogs produces a sudden and severe hypoglycemia. Soskin[20] points out that the blood sugar in the normal animal remains relatively constant under diverse conditions of feeding and fasting, whereas this is not the case in the diabetic organism. He elaborates the concept of the homeostatic regulating mechanism of the blood sugar level, using the analogy of the thermostat in a house. The thermostat is set at about 100 milligrams of sugar. When the level drops ("house cooling" as by exercise or fasting) increased liver glycogenolysis results in glucose pouring into the blood stream to raise the level. Similarly an increase in temperature of the house causes the furnace to shut off; namely, the output of glucose from the liver is inhibited and glycogen storage therein occurs. This sounds simple, but the entire process is mediated by a complex system of enzymes and other regulators, especially the secretions of the endocrines. In diabetes this regulatory mechanism is disturbed through either dysfunction of the liver, insufficiency of insulin or antagonistic activties of other hormones.

Enlargement of the liver is a frequent finding in diabetes. Gray[10] and his co-workers reported a study of liver function in 247 diabetics and concluded that liver disease is a frequent association of diabetes; that the involvement is much more prevalent in severe diabetes; and that failure to control the diabetic state exaggerates the liver disorder. He also reports that there is no statistically significant difference in the frequency of liver involvement in the young and older age groups.

Taub[21] reported on liver dysfunction hyperglycemia, stating that the majority of adult diabetics have a liver dysfunction; that they are more sensitive to insulin than juveniles; that symptoms are not as dramatically altered by insulin deprivation or insufficiency as are the young groups, and that treatment with a high carbohydrate and protein diet plus high doses of the vitamin B complex resulted in chemical and subjective improvement in the older groups.

Biskind[2] has pursued a similar line of thought referring to a nutritional deficiency in diabetes. This deficiency is primarily that of the B complex. It is known that estrogens are inactivated in the liver and that this process is influenced by B complex administration. Biskind's patients responded strikingly well to intensive B complex therapy showing subjective improvement, increased carbohydrate tolerance and frequently reduced insulin requirement.

Insulin

Insulin was discovered in 1921 and was first obtained in crystalline form in 1926. The pancreas contains considerable zinc, cobalt, and nickel. Salts of these metals increase the yield of precipitated insulin crystals. At the present time, solution zinc insulin crystals contain one milligram of zinc per 1,000 units of insulin. The standard strength of insulin is 24 units per milligram of crystals. Under the microscope the crystals look like dice with rounded edges. This cuboidal appearance, however, is an illusion. The crystal actually has been shown to be a twinned rhombohedron. The molecule contains 18 amino acids, according to Scott and Fisher, and its hypoglycemic effect is due to the cystein, amino, and other phenolic groups. It is hydrolyzed by pepsin, trypsin and other protein enzymes. The effect is therefore dependent upon the protein in the molecule. This accounts for its inactivation when taken orally. Any process which increases proteolytic enzymes (protein catabolism) as in infections, fever, anoxia, trauma, hyperthyroidism and anterior pituitary excess causes an inhibition of insulin action. Hagedorn[15] states that until more is known of the biochemistry of the insulin molecule, its oral use is ineffectual. The molecule also contains sulphur, and total inactivation results when one-third of the sulphur content is reduced. Beef and hog pancreas is the chief source for commercial insulin at present.

Many insulins have been developed in the past twenty-five years, but at present four are on the market, namely, regular or standard insulin, solution zinc insulin crystals (crystalline insulin), pro-

tamine zinc insulin (PZI) and globin insulin. Through the efforts of the American Diabetes Association, it is hoped that soon only two strengths of insulin will be marketed, namely U 40 and U 80, to lessen the confusion that prevails. Regular and crystalline insulin are interchangeable as to indication for use and duration of effect.

Although PZI is a great boon to the diabetic, and permits many to be controlled with a single injection daily, its limitations soon become evident. Often it must be supplemented by shorter acting (crystalline) insulin. Efforts to combine long-acting PZI and short-acting soluble insulin began shortly after the development of PZI by Hagedorn in 1935. Peck[16] and Colwell[3] have reported most extensively on this recently. Since PZI contains an excess of free protamine, proportions of less than one part of soluble insulin to one part of PZI results in a precipitation of the soluble insulin with a loss of its prompt acting effect. Therefore, to obtain an effective mixture, soluble insulin must be in excess. Peck and Colwell report that the most effective ratio appears to be two parts of short-acting insulin to one part of PZI. Ratios of three to two, three to one, and intermediate proportions will be required in individual instances. Colwell believes that the resultant mixture is a new substance with a monophasic action, rather than one having a dual (short and long acting) effect. The duration of action of the mixture is dependent upon the zinc content, the pH, and the protamine content. The addition of zinc prolongs insulin action; lowered pH accelerates its action as does a lowered protamine content. Mixtures work nicely in many instances and contribute greatly to the lessening of the diabetic's inconvenience by permitting of only one daily injection.

Insulin functions probably as a catalyst or modulator in the phosphorylation of glycogen to hexose-1-phosphate, the first step in glycogen transition. After phosphorylation, there are several pathways open to the fate of glucose which in itself is to all intents and purposes metabolically inert. The recent work of Price, Cori and Colowick[18] shows that the pyruvate oxidation in the diabetic is normal, but that glycogen resynthesis is impaired. They have shown that insulin can act in a cell free system at the level of the hexokinase reaction. Here it facilitates the release of energy in the action of the compounds adenosine-diphosphate and adenosine-triphosphate. This action can be inhibited by adrenal extract and anterior pituitary extract. Other known functions of insulin[20] are: increase of liver and muscle glycogen in the diabetic organism; inhibition of liver glycogenolysis; inhibition of deamination of amino-acids (protein sparing effect); antiketogenesis; and enhancement of carbohydrate utilization and storage. Soskin states that insulin enables the body to do at low or physiological sugar concentrations that for which it would otherwise require very high sugar levels. It enhances the rate at which these processes function.

Vascular Complications

There is no doubt that insulin has prolonged the life of both the young and old diabetic. However, despite insulin, complications involving the vascular system have not been reduced. Dolger[15] reported an evaluation of vascular damage in 200 patients. Of fifty-five well controlled children under twenty years of age, twenty had some degree of vascular degeneration. He points out that the vascular degeneration becomes evident on an average after thirteen years' duration of the diabetes. Priscilla White found 70 per cent of diabetic women having the disease over twenty years to have demonstrable vascular changes. The development of vascular changes is apparently not influenced by adequate control of the diabetes. However, Dillon[15] points out that failure to control these patients hastens vascular complications and emphasizes the best control possible to lessen these changes.

Pregnancy and Diabetes

Pregnancy is regarded as a complication of diabetes rather than as a normal occurrence. Priscilla White[24] has classified the various factors in the pregnant diabetic as to maternal, obstetrical, fetal, placental and chemical phases. Hydration of both the mother and fetus is common. Eighty per cent of the babies are large due to obesity, edema or splanchnomegaly. She has formulated a regimen of therapy featuring estrogen and progesterone administration, salt restriction, protein at 2 grams per kilo body weight, carbohydrate ranging from 180 to 250 grams and adequate insulin. Her survival rate has thereby increased to 90 per cent.

In surgical complications of the lower extremities, refrigeration anesthesia for amputations has received considerable attention. Allen of New

York has ardently advocated its use. The advantages rest primarily in the marked lessening of shock to the patient, and practically no disruption of the patient's usual regime because of surgery. Many surgeons prefer to use spinal or intravenous pentothal anesthesia for amputations, however.

Coma

Coma is a waning complication in diabetes and is generally regarded as entirely preventable. Ketosis is difficult to produce without a preceding episode. Koehler[15] gave controlled diabetics 2,000 calories extra in fat and did not provoke ketosis unless a gastrointestinal upset ensued. Dillon points out that ketosis is seldom seen when adequate insulin is used unless an infection is present. Mosenthal[15] emphasizes, too, that some disorder as a gastrointestinal disturbance, alcoholism, or infection must be present to provoke coma. It is generally agreed that there is a profound insulin deficiency in coma and that insulin must be given in large amounts. It is commonly accepted that in addition to a vigorous attack on the glycosuria with insulin, prompt correction of the secondary water and mineral depletion by the use of parenteral fluid administration is essential. The use of parenteral glucose solutions in ketosis and coma is somewhat equivocal. The argument against its use is that it exaggerates the disorder since adequate sugar is present in the body needing insulin to utilize it. On the other hand, proponents of glucose contend there is an actual depletion of sugar and that it must be given with adequate insulin to facilitate glycogen deposition in the liver and hence suppress ketone body oxidation.

Intercapillary Glomerulosclerosis

An interesting pathological lesion receiving more attention recently is intercapillary glomerulosclerosis. Described by Kimmelstiel and Wilson[12] in 1936, it was thought to be specific for diabetes mellitus. The incidence varies from 40 to 60 per cent. It is featured clinically by mild to moderately severe diabetes, hypertension, albuminuria and edema. Goodhof[8] showed that the incidence curve rises sharply in the third decade, and after a duration of the diabetes for over six years. Hyaline changes in the pancreas closely parallel the occurrence of intercapillary glomerulosclerosis.

Adequate Control

Just what is meant by good control of the diabetic has been debated since the discovery of insulin. Various dietary schemes have been elaborated and many regimen ranging from great restriction of one or more of the dietary components to a free diet have been discussed. Mirsky[13] commented recently in an editorial that the academic problems of the diabetic's metabolism matter little and that the good individualized discriminative care the physician gives his patient is the more significant factor. Great controversy centers around the degree of glycosuria to be permitted. Tolstoi[15] disregards glycosuria up to 50 grams daily providing the patient is free of complications and feeling well. Anderson[15] is emphatic in his plea for relative aglycosuria. He emphasized consideration of the effect of an elevated blood sugar level on the intrinsic islet mechanism and believed that control should be as strict as possible consistent with the patient's well being. From 4 to 12 per cent of diabetics defy control.

The obese glycosuric differs in certain respect from the thin diabetic. Simple weight reduction usually eliminates glycosuria and causes the tolerance curve to become normal. The obese diabetic does not need insulin as a rule.

The problem of treating hyperglycemia *per se* is unsettled. Many elderly persons tending to the heavy side will have hyperglycemia with a sugar-free urine. They may not feel well if the blood sugar is reduced by insulin. Mosenthal[14] has long believed that a high blood sugar in itself is not harmful. Since insulin has not lessened the incidence of many complications in the diabetic, and since glycosuria and hyperglycemia are characteristic of diabetes and islet cell exhaustion has been shown to occur under these circumstances, it would appear logical to attempt to approximate the normal in the management of such cases.

Jackson[15] pointed out that in the diabetic child, poor control resulted in retarded growth and maturation. He stated that the earlier children were controlled before puberty the more normal was their development.

Frank Allen[15] of Boston says that the primary objective of treatment of diabetes is thorough control of the glycosuria and hyperglycemia by diet and insulin. He abandons this objective when he fails to achieve it after one year of intensive treatment; when it cannot be obtained at the expense of frequent insulin reactions; and when the patient is over sixty years of age. The majority of physicians treating diabetes mellitus keep this objective in mind. Carelessness of manage-

ment begets a careless patient who soon finds himself in difficulties of one sort or another.

Diet

It has long been known that the metabolism of protein yields some carbohydrate. Whether it is as specific as a 58 per cent yield, so commonly accepted, may be open to question. Soskin[20] points out that only three amino acids, aspartic, glutamic and alanine, have been shown to be converted to carbohydrate by a known pathway by separate investigators.

Conn[4] has employed the concept of conversion of protein to carbohydrate in the treatment of hyperinsulinism by prescribing a diet high in protein and low in carbohydrate. The conversion is slow and the stimulus for insulogenesis is minimal. Emphasis on adequate protein has been prominent in the literature in various phases of medicine. The surgeon appreciates its value in tissue repair, the pediatrician in growth and the obstetrician in maternal and fetal health. Best[15] thinks clinicians are using barely the minimum of protein at one gram per kilo. Adlersburger[15] pointed out that using 100 grams of protein in the diet had no untoward effect on insulin requirements. It improves hypoproteinemia and caused the patients to feel better.

Frank Allen also states that sufficient protein (up to 100 grams) was accompanied by less blood sugar fluctuation and a greater satiety value of the diet. He stressed the objective of individual control of the patient and consideration of the pathologic physiology of diabetes in formulating the diet. Not only must the strain on the islet cells be relieved but consideration of such other organs as the liver must be made. He pointed out that in achieving the objective of control, at a certain point factors peculiar to the patient such as eating, the diet, and his strength, may be overlapped by factors of the chemistry, such as insulin dosage and hypoglycemia, with resultant distress and disadvantage to the patient.

In respect to the diet, Lawrence of London, himself a diabetic, says that the diet must be humane as well as scientific. Too much restriction will result in a hungry, unhappy and uncooperative patient. The trend in diet formulas appears to be toward a higher protein, higher carbohydrate and moderate caloric restriction. This implies fat restriction. Carbohydrate liberality will be controlled by individual tolerance and insulin sensitivity. This again stresses the necessity for individualized treatment of the diabetic patient.

Summary

It seems generally agreed that the diabetic syndrome involves an imbalance of many factors including the endocrines, the liver and the diet. Disorder of the pancreas is not the sole factor in human diabetes. There is a relative insulin inadequacy in any event resulting either from insufficient insulin production or inhibition of its function somewhere in the cycle. The chief function of insulin appears to be its influence on the rate of carbohydrate utilization wherein it acts as a catalyst in a complex system of enzymes and co-enzymes. The diet must be humane, adequate. individualized and consistent with the disordered physiology involved in diabetes. Insulin has not lessened certain degenerative vascular complications in the diabetic, although it has greatly prolonged the lives of all who use it. The primary object of treatment is to achieve as thorough control of the deranged chemistry as is consistent with efficient individual body economy.

Bibliography

1. Althausen, T., and Stockholm, M.: Am. J. Physiol., 123: 577, 1938.
2. Biskind, M., and Schrier, H.: Exper. Med. & Surg., 4:299, (Nov.) 1945.
3. Colwell, A. R.: Arch. Int. Med., 74:33, (Nov.) 1944.
4. Conn, J. W.: J.A.M.A., 115:1669, 1940.
5. Copp, E., and Barclay, A.: J. Metabol. Dis., 4:445, 1923.
6. Dunn, J., Sheehan, H., and McLetchie, N.: Lancet, 1:484, 1943.
7. Gellerstedt, N.: Beitr. Z. Path., 101:1, 1938.
8. Goodhof, I.: Ann. Int. Med., 22:373, (Mar.) 1945.
9. Gomori, G.: Bull. New York Acad. Med., 21:99, (Feb.) 1945.
10. Gray, S., Hook, W., and Batty, J.: Ann. Int. Med., 24:1, (Jan.) 1946.
11. Haist, R. E., and Best, C. H.: Proc. Am. Diabetes A., 1941.
12. Kimmelstiel, P., and Wilson, G.: Am. J. Path., 12:83, 1936.
13. Mirsky, I.: Editorial, Proc. Am. Diabetes A., 1945.
14. Mosenthal, H. O.: Proc. Am. Diabetes A., 1941.
15. Papers and roundtable discussion at meeting, Am. Diabetes A., Toronto, 1946.
16. Peck, F. B.: J. Indiana M. A., 363:340, (July) 1943.
17. Peck, F. B.: Proc. Am. Diabetes A., 2:69, 1942.
18. Price, W., Cori, C., and Colowick, S.: J. Biol. Chem., 100: 635, 1945.
19. Scott, D. A., and Fisher, A. M.: J. Clin. Investigation, 17: 725, 1944.
20. Soskin, S., and Levine, R.: Carbohydrate Metabolism. University of Chicago Press, 1946.
21. Taub, S., Shlaes, W., and Rice, L.: Ann. Int. Med., 22: 852, (June) 1945.
22. Warren, S.: The Pathology of Diabetes Mellitus. Philadelphia: Lea and Febiger, 1938.
23. Warren, S., and Root, H.: Am. J. Path., 1:415, 1925.
24. White, Priscilla: J.A.M.A., 128:181, (May) 1945.

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MSMS

Ice cream manufacture in the United States during 1946 was enough to give every person twenty-one quarts.

Should Patients Be Ambulatory after Lumbar Puncture?

Observations on the Frequency, Cause and Prevention of Postlumbar Puncture Reactions

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THE LITERATURE on postlumbar puncture reactions is voluminous. Adding to it can be excused only by an attempt to outline what seems to be the best method of postpuncture care in private practice, and to point out what seem to be certain fallacies in evaluating these reactions. There is great disparity of opinion as to the frequency of these reactions and as to the best methods of preventing them. The private practitioner is left bewildered amid a morass of conflicting information, unable to choose rationally whether to perform the puncture with the patient lying on his side or sitting up; whether to make it a hospital procedure followed by complete bed rest for a day or two or to go to the opposite extreme and perform the puncture in the office, with the subject returning to full activity immediately afterward.

In the present study an attempt has been made to maintain conditions as nearly uniform as possible and thus overcome the criticism which may be made of some of the earlier studies which contained numerous variables, such as differences in technique, in nursing care, and in instructions to the patient. The following conditions were established:

1. All punctures were performed by the same physician in an identical manner.
2. The nursing personnel was identical at all sessions.
3. The only instructions given to the patients were those directly concerned with the actual procedure of the puncture itself. No comment regarding possible after effects was permitted (with the exception of those patients in Group III below).
4. All patients returned to the physician who performed the puncture for evaluation of symptoms twenty-four and seventy-two hours after the puncture.
5. Standard amounts of fluid were withdrawn.

The technique of performing the puncture was the usual one with the patient sitting on the edge of an operating table. Asepsis was observed. The needles used were 20-gauge, well sharpened, short beveled with well-fitted stylets. The skin and interspinous ligament was infiltrated with 2 per cent procaine hydrochloride, using a 25-gauge needle. The spinal needle was inserted with the bevel parallel to the long axis of the body, thus splitting rather than cutting the dural fibers.[9] Withdrawal of the needle was done slowly, until fluid no longer dripped from the hub; this being an attempt to prevent herniation of the meninges into the wound. Such herniation is seemingly more frequent with rapid withdrawal which tends to drag the meninges with the needle.[9]

The patients were divided into three groups. In all three groups full activity was resumed after the puncture. Group I consisted of patients from whom 10 to 12 c.c. of cerebrospinal fluid was removed. This group established the reaction rate to be expected under the usual circumstances of ambulatory punctures. Group II was made up of patients from whom only 1.5 c.c. of cerebrospinal fluid was removed, in an attempt to determine what effect the volume of fluid removed had on the reaction rate. Group III included patients in whom the entire procedure of puncture was simulated in every detail, even to inserting the spinal needle into the interspinous ligament. In no instance in this group, however, was the epidural or subdural space entered. In an effort to evaluate psychogenic factors, all patients in this group were told that they might develop severe headaches and should go to bed if this occurred.

The severity of the postpuncture reaction was graded on the following basis:

1. *Mild:* the patient voluntarily continued on full activity although complaining of either headache or backache.

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TABLE I.

Group	Total Number Patients	SYMPTOMS							
		Mild		Moderate		Severe		None	
		No.	%	No.	%	No.	%	No.	%
GROUP I 10-12 cc. CSF removed	100	18	18	15	15	19	19	48	48
GROUP II 1.5 cc. CSF removed	76	15	19.8	5	6.5	10	13.1	46	60.5
GROUP III Simulated puncture	30	0	0	1	3	0	0	29	97

2. *Moderate:* the patient voluntarily limited his activity, spending part of the day in bed.
3. *Severe:* discomfort was so intense that the patient voluntarily remained in bed for one or more days.

Table I summarizes the findings.

From this table the following conclusions are reached:

1. The rate of postpuncture reactions is not dependent upon the amount of fluid withdrawn over a relatively wide range. (The difference in reaction rates between Group I and Group II is not statistically significant.)
2. Psychogenic influences alone are of no practical importance in producing postpuncture reactions.
3. The rate of reactions under an ambulatory regime is higher than that reported elsewhere.[1,4,6,7,10,14,16,20,21]

The literature on postlumbar puncture reactions shows considerable disagreement as to their frequency under different methods of postpuncture care. It seems likely that the difficulty of establishing standard conditions of postpuncture observation may account for a large part of this conflict. The writer has seen several centers where punctures are performed routinely on large numbers of ambulatory patients. The usual attitude of the physicians in these centers is that reactions are not unduly common, yet when the subjects are interviewed, one is impressed by the frequency of reactions. Apparently the procedure has become so routine that the untoward after effects have come to be ignored by the physicians. In private practice such reactions come to light all too often and cannot be ignored.

The tabulation of reports on postlumbar puncture reactions (Table II) is indicative of the disagreement which exists.

As to the mechanism underlying these reactions there are again many conflicting opinions. Probably the most generally accepted theory is that the reaction is due to the loss of fluid which forms the supporting cushion of the brain.[15] The total volume of the cerebrospinal fluid is variously reported as ranging from 60-80 c.c.[11] to 150 c.c.[19] If the postpuncture reaction is due to the removal of fluid only, it is inconceivable that the loss of so small a quantity as 1.5 c.c. could alone account for the reaction. It has been suggested that leakage from the puncture wound was the cause of the phenomenon.[18] This theory is supported by the demonstration that methylene blue injected into the cerebral ventricles of cadavers diffuses into the lumbar dural sac only if lumbar puncture is done.[12] Further confirmation is supplied by the finding that indigo carmine injected into the subarachnoid space via a lumbar puncture appears in the urine eight minutes after withdrawal of the spinal needle, but if the needle is left in place, does not appear for sixty-three minutes.[3] The results of plugging the puncture wound with gut also indicate the part played by leakage. Nelson[17] in a well controlled study reported a reduction in reactions from 16.9 per cent to 4.9 per cent by using this technique. Heldt and Whitehead,[10] although recording 54 per cent reactors with the gut plug technique and only 35 per cent reactors without the plug, noted that the average duration of the reaction was eighty-nine hours without the plug, only forty-five hours with the plug.

Three cases observed in the writer's experience of some 10,000 lumbar punctures further corroborate the leakage theory. In these three instances, despite a clean puncture and careful withdrawal of the needle, there was prolonged leakage of cerebrospinal fluid through a dural herniation into the soft tissues. This leakage was evidenced by a large

TABLE II.

Author	Number of Cases	Post-Lumbar Puncture Reaction Rate	Comment
Adler[2]	a. 77 normal patients 22 constitutionally inadequate patients	7.0% 27.0%	Psychogenic factors were considered to be of great importance in causing these reactions. The reaction was theorized to be due to increased pressure, the secretion of cerebrospinal fluid being augmented by emotional factors. The other findings in this study are not statistically significant.
Blau[3]	1. 211 cases resting on their return home after lumbar puncture in the clinic b. 110 ambulatory cases	29.2% 12.2%	Inasmuch as the rest cases were allowed to return home after the puncture and were not under observation, this is not a fair appraisal of the effect of rest.
Torbert[4]	a. 100 cases resting in the hospital for 24 hours b. 211 ambulatory cases	22.0% 20.1%	The difference in reaction rate between ambulatory and rest cases is not statistically significant. Of the reactors, 97.7% of the ambulatory cases, 41.0% of the rest cases, had reactions lasting more than one day.
Levin[5]	2217 ambulatory patients	0.7%	These punctures were performed on Army personnel. The reaction rate does not compare with any other reports and it seems likely that some observational deficiency must have existed due to the "exigencies of the service."
Stokes[6]	Several thousand	15-25%	Stokes expects this reaction rate even with every precaution.
McCarty and Raney[7]	a. 85 cases resting after puncture b. 85 ambulatory cases	16.4% 4.7%	Psychogenic factors were thought to be the basis of most reactions.
Greene[8]	250 ambulatory cases	4.0%	The advantages of a fine needle with a rounded point and proper technique were stressed as important reaction-preventing measures.
Davenport[9]	1015 ambulatory cases	32.8%	Uniformity of technique was lacking in this study, punctures being performed in different clinics by different personnel.
Heldt and Whitehead[10]	1044 cases	22.9%	The effect of activity was not studied in this series, there being no indication of the type of post-puncture care.

edematous swelling about the site of the puncture and was accompanied by headache and backache more severe and persistent than any encountered in cases without this manifest leakage. Relief was obtained only by bed rest for a week or more. These and other cases of less severe reactions do not bear out the statement that, "certainly lumbar puncture headache rarely occurs when a clean puncture is made on the first attempt."[8]

These findings, together with the observation that a marked fall in cerebrospinal fluid pressure is associated with the onset of the reaction,[13,17] completely refute attempts to explain such reactions on the basis of increased pressure. Supporters of the latter theory argue that the rapid formation of cerebrospinal fluid renders the leakage theory untenable; that large quantities, even hundreds of cubic centimeters, may be lost in cases of cerebrospinal rhinorrhea without symptoms resembling those of a postlumbar puncture reaction. In such cases, the loss of fluid is from above rather than below. Is it not probable that the supporting cushion at the base of the brain remains intact? If so, the symptoms thought to be caused by descent of the brain toward the base of the skull with possible vascular congestion and by the pull on the brain by the weight of the spinal cord cannot occur, pressure of the fluid being higher below than above.

All of this evidence forces acceptance of the concept that leakage from the puncture wound is the immediate factor causing postlumbar puncture reactions. If this is the important factor that it seems to be, obviously activity after the puncture is undesirable. Despite the previously cited reports favoring full activity after puncture, it is still felt that the conservative method, employing bed rest, is desirable, not more than 15 per cent of the cases experiencing reactions of any severity under this regime.

The importance of cerebrospinal fluid examination when indicated (and this includes all cases of syphilis) is so great that it should never be sidestepped for fear of a reaction. If finances and circumstances permit, it seems wise to do the procedure in the hospital and follow it with twenty-four hours of bed rest. Whether to perform the puncture with the patient sitting up or lying on his side is a matter of individual choice. There is no reason to believe that performing

punctures with the patient sitting up increases the reaction rate and certainly this position simplifies the procedure. The patient should lie prone for at least an hour after the puncture in the hope of facilitating the formation of a fibrin plug. No pillow should be allowed, and elevation of the foot of the bed is desirable. The use of the gut plug technique is not recommended because it adds a technical difficulty and there is some question of its producing an aseptic meningitis of brief duration. Cisternal punctures, though rarely accompanied by postpuncture reactions, are a radical procedure and have left the writer with a very bad impression after seeing two nearly fatal accidents in a series of a hundred punctures.

If hospitalization is inexpedient, the practitioner should not hesitate to perform lumbar punctures as an office procedure. The following technical points are recommended:

1. The injection of 2 per cent procaine hydrochloride into the skin over the puncture site and into the interspinous ligament, using a fine needle, not only affords a more co-operative patient, but also serves as a marker for the chosen site of puncture.

2. The spinal needle should be sharp, short beveled with a rounded point, and not larger than 20 gauge.

3. Insertion of the spinal needle should be with the bevel parallel to the long axis of the body of the patient, thus splitting rather than sectioning the dural fibers.

4. Withdrawal of the needle should be slow. The stylet should never be replaced in the needle after the subdural space has been entered. This permits fluid to drip from the needle on withdrawal until the needle emerges from the subdural space.

5. The use of a needle of the Dattner type,[5] a double needle incorporating a 25 gauge needle for actual puncture of the dura within a guide needle of 20 gauge, which is used for penetration of the skin and interspinous ligament, is most satisfactory. With a little practice it is very simple to use and the incidence of postpuncture reactions, even with ambulatory patients, is negligible. The only objection to this needle is that the fluid drips out very slowly, a half hour sometimes being consumed in collecting 12 c.c. Even this disadvantage may be partially nullified by attaching the collecting tube to the needle with a clip and allowing a nurse or lay attendant to observe the patient during the collection. The procedure may be accelerated by using a syringe for withdrawal of the fluid, but the slower method is preferred.

As for the treatment of reactions, the best measure is bed rest without a pillow and with the foot of the bed elevated. The minimum period of bed rest in the presence of a reaction should be twenty-four hours. A high fluid intake is said to be desirable. Other measures include the administration of 1 c.c. of pituitary extract intramuscularly,[2] 100 c.c. of 0.5 per cent saline solution intravenously,[2] 50 c.c. of 50 per cent glucose intravenously, 0.3 to 0.5 Gm. of caffeine sodium benzoate intravenously. In an occasional case, these measures seemingly give relief.

SUMMARY

1. A postlumbar puncture reaction rate of 50 per cent can be expected in ambulatory patients.

2. Within wide limits, the volume of cerebrospinal fluid removed has no influence on the reaction rate.

3. Psychogenic factors alone are of no importance in causing postpuncture reactions.

4. Leakage from the puncture wound is the immediate cause of the reactions.

5. Bed rest is the best prophylactic and therapeutic measure for postlumbar puncture reactions.

6. Reactions can be minimized by the use of very fine needles of the Dattner type.

BIBLIOGRAPHY

1. Adler, Harry: A study of the Headaches following Diagnostic spinal taps. New York State J. Med., 43:1328-1330, (July 15) 1943.
2. Alpers, Bernard J.: Lumbar puncture headache. Arch. Neurol. & Psychiat., 14:806-812, (Dec.) 1925.
3. Baruch: Cited in Heldt and Whitehead.[10]
4. Blau, Albert: Reactions following Spinal Puncture. Urol. & Cut an. Rev., 45:239-242, (April) 1941.
5. Dattner, Bernhard et al: The Management of Neurosyphilis. pp. 24-27. New York: Grune and Stratton, 1944.
6. Davenport, Kenneth M.: Postpuncture reactions. New York State J. Med., 39:1185-1187, (June 15) 1939.
7. Greene, H. M.: A technic to reduce the incidence of headache following lumbar puncture in ambulatory patients. Northwest Med., 22:240, (July) 1923.
8. Greenfield, J. G., and Carmichael, E. A.: The Cerebrospinal Fluid in Clinical Diagnosis. p. 15. London: Macmillan Co., 1925.
9. Hall, George W.: Personal communication.
10. Heldt, Thos. J., and Whitehead, Leston S.: Clinical studies in postlumbar puncture headaches. Am. J. Psychiat., 93:639-648, (Nov.) 1936.
11. Howell, Wm. H.: Textbook of Physiology. 13th ed., p. 662. Philadelphia: W. B. Saunders Co., 1937.
12. Ingvar, Sven: On the danger of leakage of the cerebrospinal fluid after lumbar puncture. Acta Med. Scandinav., 58:67, 1923.
13. Jacobeus, H. C., and Frumerie, K.: About the leakage of the spinal fluid after lumbar puncture and its treatment. Acta Med. Scandinav., 58:102, 1923.
14. Levin, Myron J.: Lumbar puncture headaches. Bull. U. S. Army M. Dept., 82:107-110, (Nov.) 1944.
15. MacRobert, R.G.: The cause of lumbar puncture headache. J.A.M.A., 70:1350, (May 11) 1918.

(Continued on Page 998)

Some Psychosomatic Disorders Involve the Skin

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THAT WHICH IS OBVIOUS frequently defies detection. Edgar Allan Poe utilized this theme in his story, "The Purloined Letter." The annals of science are replete with examples in which simple explanations were neglected in the search for more complex causes. This is not new. All of us at one time or another, have disdained simplicity, being seduced by the lure of a more intricate etiology. With the scales finally removed from our eyes, we meet these situations with trite remarks: "As plain as the nose on your face," "Can't see the trees for the forest," "If it were a dog it would have bitten me," or "That's so simple, why didn't I think of it before?"

If one pauses to think, it becomes obvious that the mind can physiologically influence the soma. For example, uncomplicated syncope is characterized by changes in the soma that are psychic in origin. And more to the point, some chronic fainters will explain that they always faint at the sight of blood. The mind can induce a flow of tears. Some criers will tell you that they always cry when they hear sad music. A broiled steak before the nose of a hungry man will increase the flow of saliva. Embarrassment is accompanied by dilation of the arterioles of the face. The flushing and increased warmth are measurable, concrete and somatic. Tachycardia, clammy perspiration, dry mouth, at times diarrhea, goose pimples, dilated pupils, at times dribbling of urine, elevated blood sugar[2] and dyspnea are the somatic manifestations of fear. Elevation of blood pressure may be found in rage.[2] Convulsive movements of the face and diaphragm are present in laughter. These somatic responses to the psyche are so obvious that they are indisputable.

It is also obvious that the executive element of consciousness can bring about a contraction of the biceps or any other muscle belonging to the striated or voluntary category. To be sure, we are so accustomed to this fact, that is, the movement of a muscle in response to the will, that we are prone to consider all psychosomatic physiology as being consciously initiated, and therefore consciously controllable. But such a conclusion becomes untenable upon adequate observation of the facts. Violent and persistent upheavals in the somatic physiology can be psychically induced with the consciousness adding nothing more than its presence as a powerless spectator. Ablation experiments and clinico-pathological studies ascribe voluntary movements to the functions of the cerebral cortex. If the movements are voluntary, they must be represented in consciousness. Still, automatisms, although they submit themselves to cortical interference, are for the most part beyond the sphere of conscious awareness. We are capable of performing a great number of movement patterns without performance realization. Vegetative dysfunctions and emotional aberrations are quite characteristic of certain organic subcortical diseases. A careful study of some post-encephalitic syndromes reveals relatively few changes creditable directly to the cerebral cortex. Judgment is not impaired and the patients can execute cortically directed movement. But still, many of these patients create the impression that they are peculiarly unresponsive to the fact that they are incarcerated within their own skin by a disease syndrome. It would seem almost as if their cortex was out of gear with the subcortex, the emotional and vegetative activity functioning independently of the individual's conscious needs.

On of my cases of post-encephalitic paralysis agitans, who disclosed no impairment of intellect, would urinate if he allowed his right hand to fall into his lap and would defecate if he allowed his left. Vasomotor flushes, tachycardia, "goose pimples," salivation, increased perspiration and other vegetative dysfunctions are well known phenomena in the chronic encephalitic. His sudden mood changes and cachinnation, the sudden attacks of anxiety and the unprovoked outburst of rage are just as well known.

From a study of chronic encephalitis we are forced to conclude that there is an interlocking relationship between vegetative and emotional physiology. Since vegetative responses are not operable through the executive element of consciousness, it would seem logical to deduce that emotional expressions are not consciously motivated.

I do not believe it necessary to debate the

postulates of James and Lange.[3] Suffice it to say that every emotion is accompanied by vegetative activity, subcortically excited. To illustrate, in the psychic process that leads to shame, there is a dilation of the arterioles of the face demonstrable by flushing and increased warmth. Just because the environmental situation, provocative of shame, is frequently so immediately apparent, does not justify the assumption that the flushing of the face is caused through a conscious, wilfully executed, centripetal impulse.

I do not believe it pertinent, at this time, to explain the complex modus operandi of shame. Most people, many physicians included, behave toward shame as though it were consciously engendered. They pass over the obvious with nary a pause. In consequence. the obvious is not detected. If they were to pause, they would realize that no individual would wilfully execute an emotion destructive to poise, at a time when poise might be essential to self preservation. Further, regard if you will, what happens when they consciously attempt to suppress shame. Does the shame subside at the command of the will? From episodes within the sphere of your own experiences, you know that quite the contrary occurs. But that is not all. Often the ashamed person does not know that of which he is ashamed. Therefore, in these instances at least, it would be unreasonable to conclude that the shame was consciously administered.

But to continue, the newborn infant does not possess a consciousness; at least, not a consciousness as we know it. Consciousness materializes as the child learns through experience to differentiate his own being from that of his environment. But still a newborn babe may disclose the characteristic somatic changes of fear. The babe, prior to the development of consciousness, is instinctively afraid of loud noises or falling. Forcibly impede the movements of the newborn and he will exhibit the somatic physiology of rage.

Fear is essentially a self-preservative emotion. It prepares one for fight or flight. It speedily mobilizes for quick dispatch, the energy reservoirs of the soma. But I am quite certain if we were to depend upon consciousness to supervise this mobilization, we would all be dead. To illustrate: A man is casually walking across the street. He hears the horn of an approaching automobile. If consciousness were king, it would be necessary for him to reason thusly: "Horn noise is a particular type of noise. Maybe it is a warning noise. There are many horn noises. Oh, yes, this noise is from a vehicle horn, not a steamboat, not a railroad train. Oh, I have it. It is on an automobile. Now let me see. How far away is it? Is the auto coming or going? I'm in the street. Cars always travel in the street. Is the driver of the car warning me or someone else?" Finally the pedestrian concludes he is in danger. "I'll need immediate energy. I'll summon to somatic effectiveness, the physiology of fear. Heart, beat faster for I need more blood. Muscles, become taut so that I can spring further. Liver, release glycogen to energize these additional demands upon me." And, by that time the pedestrian would be dying in the street. It has been jocosely remarked that in our metropolitan areas are two classes of people, the quick and the dead.

As with shame, the afraid person does not always know that of which he is afraid. Many people, physicians included, behave toward fear as though it were consciously mediated. At least not infrequently, a physician will advise a patient to forget his fear. From such advice, we must assume that the physician believes that the patient not only is capable of recognizing in consciousness the source of his fear, but that he is also capable of doing something about it.

I do not wish to burden you with further piecemeal dissection of the emotions. Suffice it to say that every emotion is somatically represented. The somatic physiology of the emotion is identified for the most part with the operation of the vegetative nervous system. The vegetative nervous system is the nervous system of the emotions. The vegetative nervous system is the nervous system of the organs. Organ physiology and emotional physiology are indivisable. With the intellect we reason; with the emotions we feel. Since emotional or feeling tones of varying intensities are constantly present, consistent, vegetatively energized, organ activities are constantly present. Therefore, in the study of emotions and their concomitant physiology, we are not at all oriented in a fanciful sphere of ethereal abstruseness. A study of the emotions is withal a study of energy. Refined instrumentation, the polygraph, the milliammeter capable of calibrating psychogalvanic current, not only quantitatively measure the ebb and flow of the emotional tide, but also lend information regarding the energy distribution.

The emotional or feeling tone response to an

environmental stimulus is not always a trustworthy index of the external situation. Frequently the stimulus produces neither the kind nor intensity of emotional reaction to be expected under the prevailing circumstances. It has been ascertained that the emotional pattern may be modified by the conscience. At times the emotional activity is entirely incited by conscience. The concurrent changes in the somatic physiology, because of the internal excitation, may have no contemporary relationship to the outer world. Guilt feelings are activated by conscience. Often the reason for the guilt is immediately apparent. However, an individual might suffer from an intense guilt, that incites profound psychosomatic disorders, and yet have no conscious knowledge of the real guilt source. In evaluating external reality, the conscience is often notoriously unreliable. But still this same conscience is intimately integrated with the operation of the emotions. Upon the insistence of the conscience, an individual may constantly experience embarrassment. This constant embarrassment will be somatically represented by constantly dilated facial arterioles. The persistent physiological changes may bring about actual organic changes. In consequence, the physiological activity of the embarrassment emotion may result in actual organic pathology and the process is irreversible.[1]

It is not immedately obvious, but it becomes obvious, upon closer scrutiny, that often acne vulgaris is found in selfconscious individuals. Most laymen and a limited number of physicians are prone to attribute the selfconsciousness to the unsightly blemishes of the acne. But historical research frequently reveals that this type of individual has always been shy, the shyness increasing with the advent of adolescence. A resolution of the morbid shyness frequently brings about a resolution of the acne.

The conscience may operate to repress an emotion. The pent-up energy, denied its normal outlet, will utilize a less inhibited pathway of expression. The substitute pathway may be determined to some extent by constitutional predisposition. I do not wish, at this time, to elaborate upon the internal psychology of emotional distortion. Suffice it to say that for various reasons the normal cortical discharge of an emotion is prohibited. In consequence, subcortical discharges occur, utilizing other than the normal pathways. These substitute pathways are in reality blind alleys; the aim of the emotion is not objectified. The real cause of the emotional activity is not admitted into consciousness; the energy voltage is not drained off in adequate cortical discharge. In consequence, the pent-up energy floods the vegetative end organs, inciting physiological activity that results in irreversible cellular damage. This I will illustrate by case reports.

Case Reports

Case 1.—M. R., a young woman, became afflicted by a palpable erythematous subcuticular rash, involving her face and upper thorax. The rash occurred a short time after learning that her brother's eye was blackened in a fight. This patient's skin was unblemished until she was twenty years of age. At that age she suffered her first attack of skin disease, a vesicular eruption that involved the face, elbows and knees. This initial skin derangement closely followed an automobile accident in which her sister sustained a split lip, but the patient was not physically injured. Since that accident, any attempt of aggressiveness on the patient's part brought about a skin eruption.

Case 2.—M. R., a woman patient, thirty-one years of age complained of hyperemia and "breaking out" of the skin of the upper extremities, trunk and face. A medicinal, dietary and rest regime failed to influence the skin eruption. The patient was involved in an illicit love affair. It was ascertained that the object of her affection was attempting to dissolve the relationship. An adjustment of this conflict brought about a resolution of her skin disease.

Case 3.—E. N., a woman thirty-nine years of age, suffered from allergic-like type of dermatitis. During a twenty-year separation from her husband, she practiced sexual continency. However, a reawakening of her sex urges brought about conflict with her strong ethical sense. Financial difficulties, if not motivating the renewed sexual interest, at least increased the anxiety. A solution of her biologic and economic problems terminated the dermatitis.

Case 4.—Mrs. M. M., thirty-five years of age, suffered from a skin eruption of four or five months' duration. At times her face would flush and feel "terribly hot," and it would be necessary for her to fan herself. The eruption finally became vesicular and the disfigurement caused her to discontinue work. Local applications to the face and a dietary regime were not effective in mitigating the skin condition. Finally a psychiatric history was obtained and the following facts disclosed: Prior to six or seven months ago the patient had been a trusted confidential secretary to one of the superior officers of the firm. About six months ago the internal organization of the firm was rearranged. A new office manager superseded the patient. This new office manager was rather brusk in his commands and he struck the patient as being very inconsiderate. One day, upon

my advice, she had it out with this man. My instructions she "acted out" rather literally. She flew into a rage and threw a bundle of card files across the room. The next day the skin eruption disappeared. A better understanding was reached between her and the manager. So far as I know, there has been no recurrence of her symptoms.

Case 5.—Mrs. A. J. K., thirty-five years of age, presented her self for treatment because of erythematous dermatitis that involved the neck and wrists. Alpine light therapy and Lassar's paste were not effective in reducing the skin irritation. It was learned that the wearing of wool produced an intense exacerbation of the skin lesions. Upon careful observation the following important observation was made: The skin lesions recrudesced when her husband was home. Upon tactful questioning, it was finally discovered that her husband was brutal, lacking in affection towards her, that they did not speak for days at a time and that he had embarrassed her by not meeting her financial obligations. A solution of the marital conflict brought about a resolution of the dermatitis. Since that time the patient has been able to wear wool without the wool causing a skin irritation.

Case 6.—H. E., an epileptic, twenty-eight years of age, broke out with the hives upon reading "The Silver Lute," a book given to her for a Christmas present. A re-reading of the book intensified the hives. Also, the hives were much more severe after an argument with her husband.

Case 7.—A. H., twenty-two years of age, presented herself for treatment because of a pruritic skin lesion involving her entire body. A resolution of her conflict with her mother brought about a cessation of the skin lesions.

Case 8.—M. H., a woman, twenty-eight years of age, was afflicted with a skin eruption that involved the face and neck. Because of the intermittent character of the disease, it was thought at first, that local treatments, dietary and rest regimes were beneficial. However, acute exacerbations of the eruption would occur without any apparent interruption in the treatment program. Closer observations revealed that these exacerbations were associated with increased perspiration, elevation of blood pressure, tachycardia and loss of weight. To the psychiatrist, these vasomotor changes indicate anxiety. A psychiatric history was obtained. It was learned that the patient had married against her mother's wishes. A short time later her husband died. Following this episode each new development of heterosexual interest brought about vituperative and belittling comments from the enraged mother. The recent exacerbation of the skin lesion coincided in time with the development of a new heart interest. This new alliance was accomplished by the customary mother conflict situation. A good rapport was established and the patient was encouraged to defy her mother, pointing out that the mother unjustifiably was pre-empting the patient's prerogatives. Sufficient emotional emancipation resulted that the patient was able to marry again. A partial resolution of the mother conflict was followed by marked improvement.

Case 9.—B. H., a young woman, suffered from a generalized skin disease of many years' duration. The skin became indurated, probably as a reaction to the frequent moist weeping areas on its surface. The indurations disfigured an otherwise beautiful girl. Emotional orders of a hysterical nature were frequently in evidence. Her friends attributed the hysteria to her skin disease. There was a nocturnal pruritus, sufficiently intense to prevent her from sleeping. Long into the night, the father massaged the skin with cold cream while the mother slept. Accidentally and with no specific therapy in mind the patient was sent away from home. This was more for protection of the mother's health than for the patient's welfare. Peculiar to relate, the skin lesions subsided, the indurations, probably edematous, gradually disappeared. After several month's absence, the skin surfaces attained a condition somewhat approximating normal. She returned to Detroit and the skin surfaces slowly but surely became eczematous, pruritic and weeping. One would immediately suspect that she was sensitive to some foreign protein existing in the home. But it must be pointed out that she spent weeks upon end in the hospital in starch and oatmeal baths, anointed with this or that medicament, and still the lesions persisted. She was tested for sensitivity to foreign proteins, and the proteins to which she reacted were eliminated as far as possible from her diet and room surroundings. However, the father was allowed to visit her, and he was a very faithful father. The skin lesions persisted. Quite by accident she was again removed from the home environment and the lesions promptly subsided.

Summary and Conclusion

Emotional physiology and vegetative physiology are inseparable. The normal emotion, although subcortically incited, cortically discharges energy against an external object. On the other hand, the pathological emotion, denied normal egress, canalizing vegetative pathways, utilizes some area of the body as a target for bombardment. This bombardment produces cellular changes of pathological magnitude. Chronic lesions of the skin, that prove to be intractable to local or systemic agents of therapy, may be manifestations of deranged emotionalism. Correction of the emotional disturbance often corrects the skin disorder.

References

1. Alexander, F. Franz: Medical Value of Psychoanalysis. P. 232. 1936.
2. Cannon, Walter B.: Bodily Changes in Pain, Hunger, Fear and Rage. Pp. 49-79. 1934.
3. James and Lange: Emotions. Baltimore. 1922.

Methemoglobinemia from Nitrates in Well Water

By Frederick J. Chapin, M.D.
Bay City, Michigan

THUS FAR three papers have appeared in the literature describing methemoglobinemia in infants from the ingestion of well water containing excessive amounts of nitrates. I believe this to be the first case reported in Michigan. It is of particular interest because the child received a formula made with the high nitrate content water for only twenty-four hours and became extremely ill. The case report follows:

Case Report

B.W., four weeks old. Birth was a normal spontaneous delivery, and an uneventful postnatal development followed. The child was placed on a formula of Biolac 1 part to water 1.5 parts. On Sunday he went to the home of his grandparents where in the evening a formula was made using their boiled well water. This was used for the next twenty-four hours only. The child remained normal until about twenty hours after ingestion of the first feeding with this formula. Then he began to develop cyanosis which became severe by late evening and persisted. The alarmed parents took him to a physician* the following afternoon.

At that time physical examination by the referring physician showed an intensely cyanotic-appearing infant with slow, sighing respirations. He was unable to find any evidence of central nervous system, cardiac, or pulmonary disease, although there was distention of all veins.

About an hour later, during which time the baby had received continuous oxygen for about three-quarters of an hour, I saw the child and confirmed the referring physician's findings. It was realized that the oxygen was not reducing the cyanosis appreciably, although respirations were improved, and the baby cried.

A tentative diagnosis of methemoglobinemia from nitrates in well water was made, and 1.1 c.c./kilogram body weight of 1 per cent methylene blue was administered intramuscularly with startling results. In a half hour the distended veins became less apparent, and the body became pinkish blue. After an hour, only a very minimal cyanosis of the finger tips was still apparent, and respirations had returned to normal. Laboratory examinations, including chest x-ray, urinalysis, and blood count, were normal. There was considerable local reaction to the methylene blue which subsided without abscess formation. The child continued to improve and was discharged three days later. The parents were advised to use crystal water until the report of the well water was available.

*Dr. E. S. Huckins.

The report from the Michigan Department of Health follows:

Parents' Well Water	*Grandparents' Well Water*
Nitrates .....none	Nitrogen as nitrates ....243.5 PPM
Chlorides .....740 PPM	Chlorides .....200 PPM
Not contaminated	Bicarbonate as $CaCO_3$.....339 PPM
	Not contaminated

Discussion

1. The essential finding for a clinical diagnosis of methemoglobinemia in infancy is apparent cynosis without demonstrable cause. Cardiac, pulmonary, and central nervous system syndromes are the main causes of true cyanosis and in these severe instances can usually be ruled out clinically. Other toxic agents such as sulfonamides causing methemoglobinemia must also be considered in the differential diagnosis. In most places methemoglobin determinations are not available, and of course one would not wait for water reports before treatment.

2. Methylene blue therapy is excellent in results and apparently without danger.

3. With the increasing literature showing more cases of methemoglobinemia it would be a worthwhile project for all physicians to advise parents who must give their infants well water to have it analyzed for nitrates before the baby arrives.

Since the writing of this article a second proven case was seen in Bay City. The water in this case showed a nitrate level of 154 PPM and nitrates of 14.7 PPM.

Bibliography

1. Comly, H. H.: J.A.M.A., 129:112, 1945.
2. Ferrant, M.: J. Ped., 29:585, 1946.
3. Faucett, R. L., and Miller, H. C.: J. Ped., 29:593, 1946.

CONFERENCE OF PRESIDENTS

(Continued from Page 900)

they claim. Insurance is voluntary, and not compulsory. A tax is compulsory—that's what makes it a tax. There is need for action. The present poor relief system has great gaps, and has grown haphazard. Government must provide for this relief.

Voluntary health insurance is presently the problem of the medical profession, and is being supplied. The Government could, but should not enter this field. Always insurance has been privately developed. It has always been recognized that the indigent are the responsibility of the government, so that anyone who needs medical care may have it, and need not be denied because he cannot pay.

Reliance on and operation of the free system of medical care has made the United States the progressive country it is. Our longevity has increased to sixty-seven years. Shall we throw away that system?

Editorial

THE FAMILY DOCTOR

THE TRAINING of doctors for family and home service is occupying increasingly more attention throughout the medical world. At a conference on medical education held at the University of Michigan, May 20, 21 and 22, 1947, speakers reported that 53 per cent of the nation's doctors are now specialists, and eighty per cent of the students now in medical colleges are contemplating specializing.

Eighteen out of twenty deans of medical schools in answer to a questionnaire regarding subjects to be discussed at the next National Conference on Medical Services submitted first, "The Training and Continued Education for General Practice," and second, "Means and Methods of Stimulating Interest in Rural Medical Practice." They realize that medical educators have overemphasized specialty training. Some wrote at some length about this problem.

Several resolutions were introduced in the House of Delegates of the American Medical Association at the 1947 annual meeting in Atlantic City calling upon the specialty boards to require from three to five years of private general practice before a candidate can qualify for the specialty board examination and certificate. This thought was repeated time and again, and was mentioned by many speakers. Admiral Clifford A. Swanson, Surgeon General of the Navy, stressed the need of training in general practice, and bemoaned the tendency of young men to rush immediately into special training. Several specialty boards have denied that they have stimulated this bypassing of general practice by their requirements for special training.

Colliers' for May 17, 1947, reports the situation in Detroit while discussing the difficulty of getting a doctor for family attention. In Detroit there are 613 full-time specialists, 762 part-time specialists, and only 637 are general practitioners. In another Michigan City, in a recent survey of the seventy doctors of medicine, there were thirty-seven F.A.C.S. or American Board certificate holders, others just doing limited practice, and only twelve who would accept and make calls as general practitioners. In still another city only 20 per cent are listed and serving as general practitioners.

In Atlantic City the writer met a group of recently graduated young doctors attending the meetings who are worried about their future. All but one were planning on entering some specialty because they believe the returns in prestige and income will be greater, but also because they fear that general practice would offer too little real opportunity. They failed to appreciate the fact that there never was a better opportunity than right now. We have had a period of accelerated courses and fewer premedics because of the war, with the natural consequence of a lesser number of doctors for general or any other practice. They just are not being produced, and those who are finishing have a term to serve in the military services because of obligations to the armed forces. Also of the returned temporary military medical officers, about 20,000 are taking some form of postgraduate study, many of them planning for the specialty board examinations. The ranks of general practice, therefore, will be wide open and needful of recruits.

The deans, the educators, the leaders in medical society thought are concerned over the large percentage of young men who are planning on specialties without the intermediate step of private general practice. Maybe some of our young men will try general practice, and perchance they might find their forte.

Would the 4,700 active doctors in Michigan be interested in building up a revolving fund of $200,000 to grant medical school scholarships to young physicians who agree to spend five years in general practice in a rural area? We could at least ask the Legislature to set aside such a fund. Illinois proposed such a fund during the last Legislature. Tennessee and Georgia have made similar moves.

WHAT OF OSTEOPATHY?

WE HAVE AVOIDED the subject of osteopathy for too long a time. As editors, we have made no comments or suggestions for guidance of the profession, and as doctors we have all

had our own ideas, and different ideas of procedure, but have done nothing. Some of us are intolerant, some refuse to face facts, but in general, the profession does not agree among themselves. Still the subject will not be ignored.

Various departments of the government, national and state, have recognized osteopathy as a profession. Almost every state has granted them licenses to practice. For some years they practiced osteopathy, but they have gradually encroached upon the practice of medicine to such an extent that the general public cannot tell by their actions whether they are not in fact doctors of medicine.

The public is genuinely interested and is attempting to improve medical service. It wants the best quality, and it is up to the public to set its own criterion for such services. The medical profession may advise but should not, or at least cannot, consider themselves exclusively qualified to override or direct public opinion.

The osteopathetic profession is here, has been among us for many years and cannot be ignored. Government agencies have recognized osteopaths for care of everyone but soldiers. Many states have recognized them for services in industry, in fact, for every service medical men can render except to certify for mental conditions, and that was attempted in S.B. 215, in the 1947 Michigan Legislature.

This condition is the result of a gradual growth over a period of years. At the beginning, when a few osteopaths broke over the line and began doing types of professional practice they were not licensed to do, or prepared to do, they could not be stopped because they had captured the sentiment of the public, and every attempt to keep them in the limits of their own osteopathic services was considered persecution.

A situation is upon us and it needs the best consideration of which we are capable. We shall have more to say on this subject in the near future, but in the meantime we invite our readers' attention to a vital topic.

NEW COUNCILOR ELEVENTH DISTRICT

OSCAR D. STRYKER, M.D., Councilor of the eleventh district, has resigned because of retirement from private practice. He will be health officer of Macomb County. Dr. Stryker has been a valuable man on the Council and part of the time on the Executive Committee. He was a member at first as Speaker of the House of Delegates. When Dr. R. H. Holmes went into Army service Dr. Stryker succeeded him on the Council. We

Oscar D. Stryker, M.D.

Roy Herbert Holmes, M.D.

shall miss his genial presence and his valuable counsel.

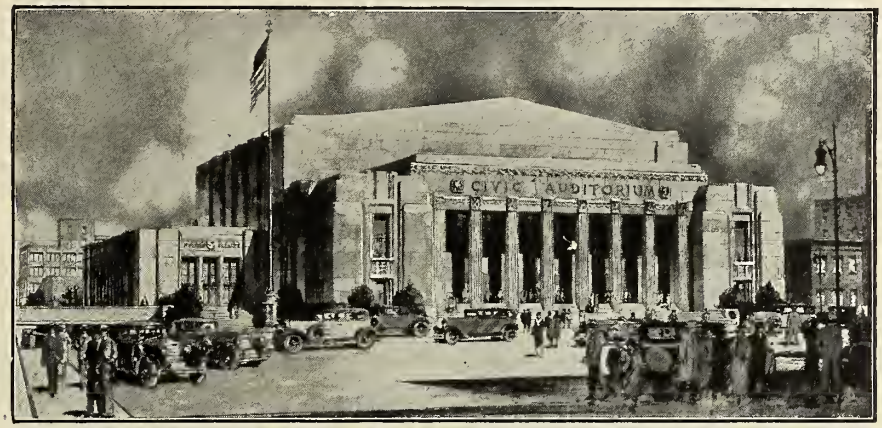
Roy Herbert Holmes has been appointed by President W. A. Hyland to fill the position on the Council made vacant by Dr. Stryker's resignation.

Dr. Holmes served on the Council for six years, three of these as editor. He was absent five years due to Military Duty and now returns to his former Council membership. Dr. Holmes brings to the Council years of experience and familiarity with state medical affairs.

We welcome a returned brother.

GRAND RAPIDS — THE CONVENTION CITY

THE TIME and the place for the 1947 Sessions of the Michigan State Medical Society could not be better selected. It is a pleasure to go to Grand Rapids, and September 22 to 26, 1947, will be ideal for weather and time of year.



Civic Auditorium—Grand Rapids

You'll like Grand Rapids because it has just everything for your pleasure, your comfort, your health and your profit. Whatever your interests, Grand Rapids affords fullest advantages. Here are all forms of recreation, large volume business, central location and convenient transportation facilities in every direction.

Founded as an Indian trading post by "Uncle" Louis Campau in 1826, Grand Rapids has grown steadily in population, in industrial and commercial importance and cultural significance.

Scenic hills, quiet streams, shaded streets form the jeweled setting in which live a happy, energetic, prosperous people. Rich in natural resources, Grand Rapids is also possessed of a superb climate, where cool breezes soothe and invigorate the heat-weary, out-state visitor in summer. Winters are moderate and stimulating.

With a contiguous area exceeding 250,000 population and a wholesale trading area of 1,552,646, Grand Rapids is truly metropolitan in all respects, with major facilities of commerce, industry, government, schools, churches, hospitals, public utilities, city transit, intercity transport, highways, airways, parks, amusement centers and residential areas.

Second city of the nation's leading industrial state, Grand Rapids is but 85 miles from the Indiana state line, 170 miles from Chicago, 150 miles from Canada at Detroit, 30 miles from Lake Michigan. Four major railroads, 21 common motor carriers and 20 airplane passenger transport flights a day in all directions assure quick connections with major markets.

Any of 250 lakes and trout streams for fishing, boating and rest can be reached within an hour from Grand Rapids. Ten minutes' drive will take you to one or more of eight sporty golf courses that welcome visitors. Bathing beaches and pools, tennis and badminton courts, skating rinks and dance pavilions, theaters, baseball parks and recreation centers afford superb amusement, in and around the city.

Grand Rapids is constant and even-keeled economically. Employment is stable. Co-operation is the keynote of industrial relations. Hydro-electric power, natural gas and Lake Michigan filtered water, furnish low-cost utilities. An efficient commission-manager municipal government rules. A charter provision limits taxation. Health and education standards are high. Churches flourish.

Ample air-conditioned convention facilities, hotels, auditoriums and exposition halls, restaurants and refreshment establishments attract scores of conventioning groups, recalling them year after year.

At the end of Lyon Street, immediately adjacent to Campau Square, stands the magnificent Grand Rapids Civic Auditorium—a structure that has won national renown for its architectural beauty and commodious utility. The Auditorium was opened to the public on January 1, 1933. Ever since its opening it has been Grand Rapids' lead-

ing center for educational and entertainment attractions and has drawn many of the greatest national, fraternal, trade and professional conventions to the city.

Club Room—Kent County Medical Society

Five thousand persons can be seated in the auditorium proper. At the north end of this main assembly room is a stage 98 feet wide and 36 feet deep, completely equipped with scenery props, full-size switchboard for border floodlights and footlights and for suffusing the auditorium illumination. The stage also has an orchestra lift, 50 feet long by 8 feet wide, which easily lifts an entire symphony orchestra from basement to stage. A subway connects with the city's largest hotel just across the street.

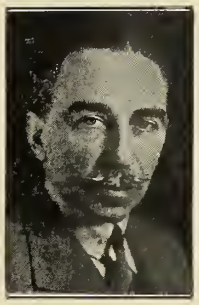
An auxiliary auditorium, known as the Black and Silver Room, is one of the most beautiful rooms of its kind in the world. It will seat 800 persons and in addition to being used as an auditorium is frequently converted into a ballroom.

In each of the two main auditoriums there is excellent and complete voice amplifying and stage equipment. The air-cooling system with which the Auditorium is equipped is considered the finest in the country—even in the warmest weather the temperature can be regulated to 70 degrees or less. There are also 44,000 square feet of fully equipped exhibit space. The Civic Auditorium was constructed at a cost of $1,500,000, funds being provided by a bond issue approved by the municipal electorate.

If golfing is one of your favorite sports, you'll find much to wax enthusiastic about in Grand Rapids. Golf is undoubtedly one of the most popular outdoor games here. There are no less than eight excellent courses in and around the city. In addition to private country clubs such as Blythefield, Cascade Hills, Green Ridge, Highlands and Kent, there are a number of good municipal and other public links—Gracewil, Indian Trails, Lincoln and Ridgemoor—all standard courses, on which the visitor may play for a nominal fee.

Monroe Avenue Looking West

THE 82nd ANNUAL SESSION
MICHIGAN STATE MEDICAL SOCIETY
Grand Rapids



WM. A. HYLAND, M.D.
Grand Rapids
President

E. F. SLADEK, M.D.
Traverse City
Chairman, Council

JOHN S. DETAR, M.D.
Milan
Speaker

OFFICIAL CALL

The Michigan State Medical Society will convene in Annual Session in Grand Rapids, Michigan, on September 21, 22, 23, 24, 25, and 26, 1947. The provisions of the Constitution and By-Laws and the Official Program will govern the deliberations.

WM. A. HYLAND, M.D.
President

E. F. SLADEK, M.D.
Council Chairman

J. S. DETAR, M.D.
Speaker

R. H. BAKER, M.D.
Vice Speaker

Attest:
L. FERNALD FOSTER, M.D.
Secretary

L. FERNALD FOSTER, M.D.
Bay City
Secretary

R. H. BAKER, M.D.
Pontiac
Vice Speaker

P. L. LEDWIDGE, M.D.
Detroit
President-Elect

DIRECTORY

Headquarters and Registration.....Civic Auditorium
Telephones: 9-1145, 9-1748, 9-1403
Hotel Headquarters.....Pantlind Hotel
Telephone: 9-7201
Scientific and Technical Exhibits.....Civic Auditorium
General Assemblies, Black and Silver
Ballroom.....Civic Auditorium
Telephones: 9-1156, 9-1751, 9-1313
Press and Publicity Room, Room F.....Civic Auditorium
MSMS Hospitality Booth,
Exhibit Floor.....Civic Auditorium
Woman's Auxiliary, Headquarters
and Registration.....Pantlind Hotel

Meeting Rooms

Pantlind Hotel

Ballroom—West of lobby—up grand staircase
Grill Room—Northwest corner (next to the Pub)
Schubert Room—Southwest corner of hotel. Use corridor from lobby.
Sadler Lounge—Southwest corner of hotel, one flight up from lobby floor.
Furniture Club—Mezzanine floor, off Writing Room, to the west.
Continental Room—South lobby.
Room 222—Second floor, turn left from elevators.
Room 322—Third floor, turn left from elevators.
Room 327—Third floor, turn left from elevators.

Civic Auditorium

Black and Silver Ballroom—west side of building (through exhibits)
Room F—(Press and Publicity Room)—south of Black and Silver Ballroom, off lobby (through exhibits)
Room G—above Room F (through exhibits)
Red Room—southwest corner, second floor, next to Room G (through exhibits)

♦ **Registration**—Tuesday noon to Friday noon, September 23-26, exhibit floor, Civic Auditorium, Grand Rapids. No registration fee to MSMS members.

Admission by badge only to all scientific assemblies, section meetings, discussion conferences and to the exhibits.

Bring your MSMS or AMA membership card to expedite registration.

♦ **Michigan Doctors of Medicine, not members,** if listed in the American Medical Directory, may register as guests upon payment of $5.00. This amount will be credited to them as dues in the Michigan State Medical Society FOR THE BALANCE OF 1947 ONLY, provided they are accepted subsequently as members by their County Medical Society.

♦ **Guests**—Members of the American Medical Association, from any state, or from a province of Canada, and physicians of the Army, Navy and U. S. Public Health Service are invited to attend, as guests. No registration fee. Please present credentials at the Registration Desk.

Bona fide doctors of medicine serving as interns, residents, or who are associate or probationary members of county medical societies, if vouched for by an MSMS Councilor or the president or secretary of a county medical society, will be registered as guests. Please present credentials at the Registration Desk.

PAPERS WILL BEGIN AND END ON TIME

Believing there is nothing which makes a scientific meeting more attractive than by-the-clock promptness and regularity, all meetings will open exactly on time, all speakers will be required to begin their papers exactly on time, and to close exactly on time, in accordance with the schedule in the program. All who attend the meeting, therefore, are requested to assist in attaining this end by noting the schedule carefully and being in attendance accordingly.

♦ **Telephone Service**—Local and Long Distance telephones will be available at entrance to Black and Silver Ballroom in the Civic Auditorium, as well as in the Pantlind Hotel.

In case of emergency, doctors will be paged from the meetings by announcement on the screen.

During meetings call 9-1813, 9-1983, 9-1313.

At other hours, call the Pantlind Hotel, 9-7201, or the Registration Desk in the Exhibit Hall, Civic Auditorium, 9-1145 or 9-1977.

♦ **Checkrooms** are available in the Pantlind Hotel, and in the lobby of the Exhibit Hall, Civic Auditorium.

♦ **Each Guest Essayist** is very respectfully requested not to change the time of his lecture with another speaker without the approval of the General Assembly. This request is made in order to avoid confusion and disappointment on the part of some members of the audience.

♦ **"Ubiquitous Hosts"**—The following Doctors of Medicine have placed themselves generally at the disposal of the 28 guest essayists who are on the Program of the 82nd Annual Session in Grand Rapids; they will demonstrate the meaning of Michigan Hospitality: N. L. Avery, Jr., M.D., W. J. Butler, M.D., C. B. Beeman, M.D., C. M. Bell, M.D., J. R. Brink, M.D., B. R. Corbus, M.D., C. V. Crane, M.D., R. H. Denham, M.D., Leon DeVel, M.D., J. C. Foshee, M.D., M. A. Hill, M.D., M. J. Holdsworth, M.D., H. P. Kooistra, M.D., J. W. Logie, M.D., R. G. Laird, M.D., J. D. Miller, M.D., C. A. Payne, M.D., L. P. Ralph, M.D., C. M. Sidell, M.D., E. W. Schnoor, M.D, W. H. Steffensen, M.D., L. J. Schermerhorn, M.D., C. P. Truog, M.D., A. B. Thompson, Jr., M.D., W. R. Torgerson, M.D., W. R. Vis, M.D., Merrill Wells, M.D., all of Grand Rapids, and W. A. Stryker, M.D., of Detroit.

Sincere thanks are extended these hosts for their tangible help in making the MSMS Annual Session an outstanding success.

You Are Cordially Invited
To Visit the

MICHIGAN STATE MEDICAL SOCIETY HOSPITALITY BOOTH

Opposite the Registration Desk

Exhibit Hall, Civic Auditorium

TWENTY-THREE DISCUSSION CONFERENCES

These question-and-answer "quiz periods" will be held Tuesday-Wednesday-Thursday-Friday, September 23-24-25-26, at 4:30 to 5:30 p.m.—except on Friday when the Surgical, Medical, and Pediatric quizzes will be held as noon-day luncheons.

An opportunity to ask questions concerning the presentations of the guest essayists, or to discuss any interesting case with the out-of-state speakers, is provided at the Discussion Conferences. A convenient form is printed in the Program on which questions may be written and handed to the Secretary of the General Assembly immediately after the termination of the lecture.

♦ **Public Meeting**—The evening Assembly of September 24—President's Night—will be open to the public. Invite your patients and other friends to this interesting meeting, to be held in the Ballroom of the Pantlind Hotel, Grand Rapids. The program is highlighted by:

8:30 p.m.—President's Address
Induction of President-Elect

9:30 p.m.—Biddle Lecture by Admiral Clifford A. Swanson, USN, Surgeon General of the Navy, Washington, D. C.

♦ **State Society Night**—Thursday, September 25.

10:30 p.m.—An evening of entertainment for MSMS members and their ladies. Ballroom, Pantlind Hotel, Grand Rapids.

♦ **Scientific and Technical Exhibits**—119 displays—will open daily at 9:00 a.m. and close at 5:00 p.m. except Tuesday when the show opens at noon and except Friday when the show closes at 11:30 a.m. Frequent intermissions to view the exhibits have been arranged before, during and after the General Assemblies. The public is barred from the exhibits.

PLEASE REGISTER AT EVERY BOOTH

♦ **Burton R. Corbus, M.D.,** Grand Rapids, is General Chairman of the Grand Rapids Committee on Arrangements for the 1947 MSMS Annual Session.

♦ **Committee on Scientific Exhibits**—J. W. Logie, M.D., Grand Rapids and John M. Wellman, M.D., Lansing.

♦ **Press Relations Committee** for the scientific session—C. A. Payne, M.D., Chairman, assisted by G. T. Aitken, M.D. and J. R. Brink, M.D., all of Grand Rapids.

♦ **Guest Golf**—The Chairman of the Grand Rapids Committee has arranged that MSMS members may play at all country clubs in the Grand Rapids District upon presentation of MSMS Membership Card and payment of greens fees.

♦ **Transportation**—The Pere Marquette Streamliners afford a convenient means of transportation to the MSMS Annual Session in Grand Rapids for hundreds of physicians in the central and southeastern part of the State. The General Assemblies have been so arranged in 1947 (from Tuesday noon to Friday noon) that doctors may arrive and depart conveniently on the Streamliners. Order reservations well in advance.

♦ **The Committee Organization Dinner,** a meeting of MSMS Committee chairmen appointed by President-Elect P. L. Ledwidge, M.D., to serve during the year 1947-48, will be held Tuesday, September 23, in the Sadler Lounge, Pantlind Hotel, 7:00 p.m.

♦ **Register at Every Booth**—there is something of interest or education in the large exhibit of 119 scientific and technical displays. Stop and show your appreciation of the exhibitors' support in helping to make successful the 1947 MSMS Convention.

♦ **Seven General Assemblies**—Twelve Sectional meetings—Twenty-three Discussion Conferences on September 23-24-25-26.

♦ **House of Delegates, MSMS,** convenes Sunday, September 21 at 2:00 p.m., Ballroom, Pantlind Hotel; it will hold two meetings on Monday, September 22, at 10:00 a.m. and at 8:00 p.m., and conclude with a breakfast and meeting Tuesday, September 23, at 8:00 a.m.

♦ **Parking**—Please do not park your car on the street. Convention parking near the Civic Auditorium will be marked off with suitable sidewalk signs. The Grand Rapids Police Department will issue courtesy cards (at Registration Desk) for out-of-town autos, which give parking privileges but do not apply to metered spaces. Nearby parking lots are available, as well as convenient indoor parking facilities. The indoor parking rate at the Pantlind Garage is $1.00 for twenty-four hours. This is close to the Pantlind Hotel.

THE WOMAN'S AUXILIARY
to the
Michigan State Medical Society
Presents an
ATTRACTIVE PROGRAM
To which the wife of every MSMS member is Cordially invited

♦ **Meetings of Special Societies, Alumni and Auxiliary Groups.**

1. **Michigan Society of Anesthetists,** Thursday, September 25, Room 222 Pantlind Hotel, 7:00 p.m., dinner.
2. **Detroit Urological Society,** Tuesday, September 23, Room 222, Pantlind Hotel, 7:00 p.m., dinner. Speaker: George H. Ewell, M.D., Madison, Wisconsin—"The Surgical Complications of the Polycystic Kidneys."
   The Detroit Urological Society will sponsor a pyelogram clinic on Wednesday, September 24, from 2:30 to 4:30 p.m. in Parlor G, Civic Auditorium, Grand Rapids. Members of the DUS and all other MSMS members who are interested are cordially invited.
3. **Michigan Pathological Society,** Friday, September 26, Room 222, Pantlind Hotel, beginning at 12:00 Noon and continuing through Friday afternoon and evening and also Saturday morning, September 27. Alan Moritz, M.D., Boston, Mass., and Mr. F. Roland Allaben, LL.B., G.R., will be the principal guest speakers.
4. **Alumni of Northwestern University School of Medicine** will meet Wednesday, September 24 at the Peninsular Club, Grand Rapids, 12:30 p.m. The luncheon is being arranged by Co-chairmen L. S. Griffith, M. D., P. W. Willits, M.D., J. H. Beaton, M.D., H. J. Damstra, M.D. and E. W. Schnoor, M.D., all of Grand Rapids.
5. **Alumni Association of Loyola University School of Medicine** will meet Tuesday, September 23, Room 322, Pantlind Hotel, 7:00 p.m., dinner.
6. **Wayne University Alumni Association** will hold "open house" from Tuesday noon to Friday noon, September 23-26—Parlor D, Mezzanine floor, Pantlind Hotel.
7. **The Medical Assistants Conference**—Wednesday, September 24. Schubert Room, Pantlind Hotel, 4:00 p.m., followed by dinner at 6:30 p.m.
   Program:
   (a) "Medical Economics and What the 'Lefts' are Thinking"—L. Fernald Foster, M.D., Bay City, Secretary, Michigan State Medical Society.
   (b) "What the Michigan Medical Profession is Doing—The Answer of the 'Rights'"—Jay C. Ketchum, Detroit, Executive Vice President, Michigan Medical Service.
   (c) "Health in a Package"—Hugh W. Brenneman, Lansing, Public Relations Counsel, Michigan State Medical Society.
   (d) "The Pacific was not so Pacific"—(Illustrated by motion pictures) J. Duane Miller, M.D., Grand Rapids, Councilor Fifth District, Michigan State Medical Society.
   Secretaries of all MSMS members are cordially invited to attend this informative Conference. No fee.

♦ **Postgraduate Credits** are given to every MSMS member who attends the Annual Session.

THE 119 EXHIBITS WILL REMAIN OPEN FOR YOUR INSPECTION UNTIL 5:00 P.M. ON TUESDAY, WEDNESDAY, AND THURSDAY; AND 11:30 A.M., FRIDAY

Have You Made Your

HOTEL RESERVATIONS?

MICHIGAN STATE MEDICAL SOCIETY

82nd Annual Session

Grand Rapids, September 23-24-25-26, 1947

The reservation blank below is for your convenience in making your hotel reservations in Grand Rapids. Please send your application to J. W. Logie, M.D., Chairman of Housing Committee, c/o Pantlind Hotel, Grand Rapids, Michigan. Mailing your application now will be of material assistance in securing hotel accommodations.

As very few singles are available, registrants are requested to co-operate with the Housing Committee by sharing a room with another registrant.

J. W. Logie, M.D., Chairman, Housing Committee,
Michigan State Medical Society Annual Session,
c/o Pantlind Hotel, Grand Rapids, Michigan.
Please make hotel reservation(s) as indicated below:

.....Single Room(s)

.....Double Room(s) for .....persons

.....Twin Bedded Room(s) for ....persons

Arriving September .....hour.....A.M.....P.M.

Leaving September .....hour.....A.M.....P.M.

(Names and addresses of all applicants including person making reservation).

Name	Address	City	State

Date ..... Signature .....

Address ..... City.....

'. Roland Allaben, LL.B.

R. J. Armstrong, M.D.

Joseph D. Aronson, M.D.

W. Wayne Babcock, M.D.

Archibald D. Campbell, M.D.

Russell L. Cecil, M.D.

George M. Curtis, M.D.

Michael E. DeBakey, M.D.

Claud F. Dixon, M.D.

Frederick E. B. Foley, M.D.

Harry Gold, M.D.

Russell L. Haden, M.D.

Stuart W. Harrington, M.D.

Wallace E. Herrell, M.D.

L. Emmett Holt, M.D.

Andrew C. Ivy, M.D.

Reynold A. Jensen, M.D.

John R. Lindsey, M.D.

Clifford B. Lull, M.D.

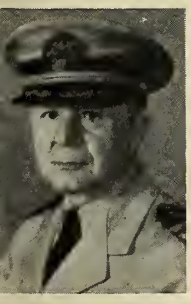
Alan R. Moritz, M.D.

C. S. O'Brien, M.D.

Paul A. O'Leary, M.D.

R. V. Platou, M.D.

Herman M. Pollard, M.D.

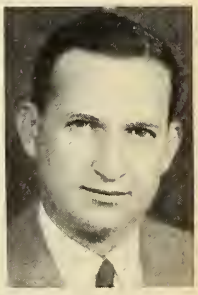

Louis Schwartz, M.D.

Wendell G. Scott, M.D.

Clement A. Smith, M.D.

Allen O. Whipple, M.D.

Frank E. Whitacre, M.D.


Robert H. Williams, M.D.

Woman's Auxiliary

Mrs. Retla Alter

CONVENTION COMMITTEES

Mrs. Joe De Pree.....Convention Chairman
Mrs. Willis L. Dixon.....Convention Co-chairman
Registration and Credentials—Mrs. John Ten Have, Chairman
Finance—Mrs. A. M. Moll
Decoration—Mrs. Leland M. MacKinley
Press—Mrs. Ralph L. Fitts
Hospitality—Mrs. Jos. L. McKenna
Printing—Mrs. Henry P. Kooistra
Get-Acquainted Hour—Mrs. Merrill Wells
Banquet and Luncheon—Mrs. William L. Rodgers
Place—Mrs. William Hyland
Tickets—Mrs. John F. Failing
Program—Mrs. Fred C. Brace

Program

Tuesday, September 23, 1947

9:30 A.M. Opening of Registration

Pantlind Hotel Ballroom Lower Landing, Grand Rapids

6:00 P.M. Dinner for Past Presidents and Secretaries Club of State Auxiliary

Peninsular Club, Grand Rapids
Hostesses, Grand Rapids members.

Wednesday, September 24, 1947

9:30 A.M. Registration

Pantlind Ballroom Lower Landing

12:00 A.M. Luncheon and Pre-convention Board Meeting

For Committee Chairmen and County Presidents of 1946-47 and Presidents of 1947-48

4:30 P.M. Get-Acquainted Hour

Honoring Mrs. Eustace Allen, National President, Continental Room

6:30 P.M. Banquet (informal)

Grill Room, Pantlind Hotel
Presiding: Mrs. Retla Alter
Invocation: Mrs. Robert M. Eaton
Welcome: Mrs. Joe De Pree
Presentation of Past Presidents
Presentation of honored guests
Presentation of Speaker—Mrs. Mary Lou McDonough
Topic: "The Doctor After Hours"

8:30 P.M. MSMS President's Night

Biddle Oration

Thursday, September 25, 1947

10:00 A.M. Annual Meeting

Red Room, Civic Auditorium, Grand Rapids
Presiding: Mrs. Retla Alter
Address of Welcome: Mrs. Leon Sevey
Response: Mrs. Leonard Himler
In Memoriam: Mrs. Michael Murphy
Minutes of the Twentieth Annual Meeting: Mrs. John W. Wholihan
Convention Rules of Order: Mrs. David M. Kane
Resolutions: Mrs. C. C. Roche
President's Message: Mrs. Retla Alter
Report of the Treasurer: Mrs. Homer Stryker
Report of the Auditor: Mrs. Homer Stryker
Reports of Standing Committees
Report of County Presidents
Election of Officers
Installation of Officers: Mrs. Guy L. Kiefer
Presentation of President's Pin
Address: Mrs. T. Grover Amos

1:00 P.M. Annual Luncheon

Grill Room, Pantlind Hotel.
Presiding:
Invocation: Mrs. Harold E. Veldman
Speaker: Mrs. Robert Sailors
Topic: "Contemporary Textiles"

3:00 P.M. Post-convention Board Meeting

Room 324, Pantlind Hotel
Presiding: Mrs. T. Grover Amos
This is compulsory for 1947-48 officers, County Presidents, and Committee Chairmen

10:00 P.M. "State Society Night"

Dance and Floor Show—Ballroom, Pantlind Hotel
Admission by card only

Eighty-Second Annual Session - 1947

PROGRAM OF SECTIONS AND GENERAL ASSEMBLIES

Program of Sections

TUESDAY NOON
Sept. 23, 1947,

12:00 to 1:30 p.m. (luncheons)

SECTION ON DERMATOLOGY AND SYPHILOLOGY

Room 222, Pantlind Hotel (Second floor behind elevators and to the West)

Chairman: L. W. Shaffer, M.D., Detroit
Secretary: Ruth Herrick, M.D., Grand Rapids

DERMATOLOGICAL PROGRAM

"Dermatitis from Wearing Apparel"
Louis Schwartz, M.D., Washington, D.C.

Isolated cases of allergic dermatitis from wearing apparel are constantly occurring. Occasionally large outbreaks occur from fabrics containing new chemicals of unknown toxicologic properties. Dermatitis from wearing apparel is usually due to allergy to tbe finishes and dyes, rarely from allergy to the fibers themselves.

The diagnosis of dermatitis from wearing apparel is made from the history of the onset and course, the site and morohe of the eruption and is confirmed by positive patch tests with the offending article.

While it is impossible to prevent isolated cases of allergic dermatitis from wearing apparel outbreaks can be prevented by having the irritant properties of new fabric processive chemicals and dyes tested by the prophetic patch test devised by the author and not using those which have strong sensitizing properties.

* * *

SECTION ON RADIOLOGY, PATHOLOGY, AND ANESTHESIOLOGY

Sadler Lounge, Pantlind Hotel (Southwest corner of hotel, one flight up from mezzanine floor)

Chairman: (Path.) S. E. Gould, M.D., Eloise
Secretary: (Rad.) J. E. Lofstrom, M.D., Detroit
Secretary: (Anes.) H. J. VanBelois, M.D., Grand Rapids

RADIOLOGICAL PROGRAM

"Prolapses of the Gastric Mucosa as a Cause of Gastrointestinal Symptoms"
Wendell G. Scott, M.D., St. Louis, Mo.

Prolapses of the gastric mucosa occur frequently but have often been interpreted as duodenal ulcer, duodenitis, et cetera. It is important that we recognize the defect of the prolapsed gastric mucosa and not confuse it with that of a duodenal ulcer.

Typical case histories with the accompanying radiographs will be shown in lantern slides. A short colored movie has been prepared to demonstrate the operative findings and the appearance of the prolapsed gastric mucosa.

TUESDAY AFTERNOON
September 23, 1947

First General Assembly

Black and Silver Ballroom, Civic Auditorium
D. W. Meyers, M.D., Ann Arbor, *Presiding*
L. Fernald Foster, M.D., Bay City, and F. W. Baske, M.D., Flint, *Secretaries*

P.M.

1:40 **"The Early Diagnosis of Pancreatic and Ampullary Growths, with an evaluation of Surgical Therapy"**

Allen O. Whipple, M.D., New York, New York

Emeritus Valentine Mott Professor of Surgery, Columbia University, New York City; Clinical Director at the Memorial Hospital, New York City.

Early diagnosis of tumors of the pancreas and ampullar area and their differentiation by means of x-ray and biliary and pancreatic function tests will be discussed. It is essential to remove these growths while still localized if the operations are to be more than palliative. These patients must not be observed and studied until they have become deeply jaundiced with liver and kidney damage and until the growth has spread to the lymphatics and liver. The analysis of the operative results from several of the clinics reporting surgery of the pancreas will be included.

2:00 **"The Diagnosis of Jaundice from a Therapeutic Viewpoint"**

Andrew C. Ivy, M.D., Chicago, Illinois

Vice President, University of Illinois, in charge of the Chicago Professional Colleges and Distinguished Professor of Physiology.

The differential diagnosis of medical and surgical jaundice will be briefly outlined in relation to the important items of the history, physical findings, and a few laboratory tests.

2:20 **"The Investigation of Low Back Pain by Radiographic Methods"**

Wendell G. Scott, M.D., St. Louis, Missouri

Associate Professor of Clinical Radiology; Associate Director of Mallinckradt Institute of Radiology; Associate Radiologist for Barnes Hospital and Allied Hospitals in the Medical Center; National Consultant in Radiology for the Bureau of Medicine and Surgery, Navy Department, Washington, D. C.

Low back pain is a symptom arising from many causes, and careful and thorough radiographic examination is the first step in the accurate diagnosis of this symptom. The importance of properly taken x-ray films is emphasized. A brief survey is made of the common congenital anomalies and diseases of bone that cause back pain which can be readily recognized with the conventional anteroposterior and lateral views. The technique for the detection of relaxation of the sacroiliac joints is discussed. The anatomy and disorders involving the intervertebral apophyseal joints is discussed and illustrated by interesting examples. The value and improvements in the technique of spinal myelography is mentioned and an estimate is made of its present-day value.

2:45-3:45 INTERMISSION TO VIEW EXHIBITS

Twenty-Three Discussion Conferences (Quiz Periods)

All Meetings Will Be Held in the Pantlind Hotel and Civic Auditorium, Grand Rapids

Twenty-three Discussion Conferences each with a different chairman—a leader of outstanding ability in his field—will be held Tuesday, Wednesday, Thursday, and Friday afternoons, immediately following the end of the General Assembly program for the day (except on Friday when the "quizzes" will be at luncheons). Here is your chance to ask questions of the lecturers and to hear discussed medical matters of value to you in your daily practice.

TUESDAY, SEPTEMBER 23, 1947
4:30 to 5:30 p.m.

DERMATOLOGY
Room 222
Pantlind Hotel
Leader
George VanRhee
Detroit
Guest Conferee
Louis Schwartz
Washington, D. C.

RADIOLOGY
Sadler Lounge
Pantlind Hotel
Leader
J. E. Lofstrom
Detroit
Guest Conferee
W. G. Scott
St. Louis, Mo.

SURGERY
Grill Room
Pantlind Hotel
Leader
H. H. Stryker
Kalamazoo
Guest Conferee
A. O. Whipple
New York City

MEDICINE
Furniture Club
Pantlind Hotel
Leader
C. L. Hess
Bay City
Guest Conferee
A. C. Ivy
Chicago

OBSTETRICS
Red Room, Civic Auditorium
Leader
V. H. Morrissey
Flint
Guest Conferee
C. B. Lull
Philadelphia

ALL MEMBERS ARE INVITED TO JOIN IN THESE QUIZ PERIODS WITH THE GUEST ESSAYISTS

WEDNESDAY, SEPTEMBER 24, 1947
4:30 to 5:30 p.m.

UROLOGY
Parlor G
Civic Auditorium
Leader
H. L. Morris
Detroit
Guest Conferee
F. E. B. Foley
St. Paul, Minn.

PEDIATRICS
Sadler Lounge
Pantlind Hotel
Leader
J. W. Towey
Powers
Guest Conferee
R. V. Platou
New Orleans, La.

OTOLARYNGOLOGY
Room 222
Pantlind Hotel
Leader
A. C. Furstenberg
Ann Arbor
Guest Conferee
J. R. Lindsay
Chicago

MEDICINE
Furniture Club
Pantlind Hotel
Leader
Frank D. Johnson
Flint
Guest Conferees
Harry Gold
New York City
R. A. Jensen
Minneapolis, Minn.

GENERAL PRACTICE
Black and Silver Ballroom
Civic Auditorium
Leader
L. W. Day
Jonesville
Guest Conferee
R. L. Cecil
New York City

GYNECOLOGY
Red Room
Civic Auditorium
Leader
S. L. LaFevre
Ann Arbor
Guest Conferee
A. D. Campbell
Montreal

SURGERY
Ballroom, Pantlind Hotel
Leader
C. G. Johnston
Detroit
Guest Conferees
C. F. Dixon
Rochester, Minn.
G. M. Curtis
Columbus, Ohio

THURSDAY, SEPTEMBER 25, 1947
4:30 to 5:30 p.m.

ANESTHESIA
Room 322
Pantlind Hotel
Leader
N. M. Bittrich
Detroit
Guest Conferee
R. J. Armstrong
Kalamazoo

OPHTHALMOLOGY
Room 222
Pantlind Hotel
Leader
A. D. Ruedemann
Detroit
Guest Conferee
C. S. O'Brien
Iowa City, Iowa

MEDICINE
Furniture Club
Pantlind Hotel
Leader
R. M. McKean
Detroit
Guest Conferees
R. H. Williams
Boston
J. D. Aronson
Philadelphia
H. M. Pollard
Ann Arbor, Mich.

GYNECOLOGY-OBSTETRICS
Red Room
Civic Auditorium
Leader
C. R. Moe
Kalamazoo
Guest Conferee
F. E. Whitacre
Memphis

GENERAL PRACTICE
Black and Silver Ballroom
Civic Auditorium
Leader
M. H. Miller
Detroit
Guest Conferees
R. L. Haden
Cleveland

SURGERY
Grill Room
Pantlind Hotel
Leader
H. A. Ransom
Ann Arbor
Guest Conferees
M. E. DeBakey
New Orleans
S. W. Harrington
Rochester

PEDIATRICS
Sadler Lounge
Pantlind Hotel
Leader
J. H. Lewis
Wyandotte
Guest Conferee
L. E. Holt, Jr.
New York City

SYPHILOLOGY
Room 327
Pantlind Hotel
Leader
Frank Stiles
Lansing
Guest Conferee
P. A. O'Leary
Rochester, Minn.

FRIDAY, SEPT. 26, 1947
12:00 M to 1:30 p.m.
(luncheon meetings)

(Luncheon)
PEDIATRICS
Sadler Lounge
Pantlind Hotel
Leader
P. V. Woolley
Detroit
Guest Conferee
C. A. Smith
Boston

(Luncheon)
SURGERY
Grill Room
Pantlind Hotel
Leader
Ralph Wadley
Lansing
Guest Conferee
W. W. Babcock
Philadelphia

(Luncheon)
MEDICINE
Furniture Club
Pantlind Hotel
Leader
C. B. Beeman
Grand Rapids
Guest Conferee
W. E. Herrell
Rochester, Minn.

3:45 **"Diagnosis, Prevention and Treatment of Occupational Dermatitis"**

LOUIS SCHWARTZ, M.D., Washington, D.C.

Medical Director (Retired), Consultant to Office of Dermatology, U.S.P.H.S.

All cases of dermatitis occurring among workers are not of occupational origin. In order to make the diagnosis of occupational dermatitis, consideration should be given to the history of the onset and course of the eruption, its site, and to its clinical appearance. In some instances patch tests should also be performed. The keynote of prevention is to avoid as much as possible any contact with potential skin irritants. Ventilation, dust control, environmental and personal cleanliness, protective clothing and protective ointments are the principal preventive measures.

The treatment of acute uncomplicated occupational dermatitis should aim towards soothing and protecting the inflamed skin.

4:05 **"The Changes and Improvements in Obstetric Practice During the Past Twenty-Five Years"**

CLIFFORD B. LULL, M.D., Philadelphia

Director, Division of Obstetrics and Gynecology Pennsylvania Hospital; Consultant Obstetrician and Gynecologist to the Philadelphia General Hospital; Chief of Staff and Consultant to Delaware County Hospital.

Many changes and advances have been made in the practice of Obstetrics during the past twenty-five years which have resulted in a marked reduction of maternal mortality and the saving of innumerable infants. Special emphasis is placed on the management of hemorrhage during the third trimester of pregnancy, the management of toxemias, the handling of abortions, the treatment of puerperal sepsis, and the improvements in analgesia and anesthesia. Also the development of the various extra-peritoneal cesarean operations which have made it possible to operate successfully on many cases that heretofore would have to have mutilating operations performed upon the child or the uterus sacrificed. X-ray has been a distinct aid and benefit in solving the problem in cephalo-pelvic disproportion and has helped materially in making the decision of either vaginal or abdominal delivery in breach presentation. Nutrition has been found to play an important part in the prevention of many of the minor disabilities and some of the more serious complications occurring during the prenatal period. Adequate prenatal care has been developed and the public has been taught what constitutes good prenatal care. The education of both the doctor and the laity has resulted, if not in preventing, at least in recognizing various obstetric complications early enough to have them successfully treated.

4:25 **End of First General Assembly**

4:30 **DISCUSSION CONFERENCES IN DERMATOLOGY AND SURGERY** (See Page 950)

PANTLIND HOTEL

WEDNESDAY MORNING
September 24, 1947

Second General Assembly

Black and Silver Ballroom, Civic Auditorium

T. E. DEGURSE, M.D., Marine City, *Presiding*

L. FERNALD FOSTER, M.D., Bay City, and J. C. FOSHEE, M.D., Grand Rapids, *Secretaries*

A.M.

9:30 **"The Part of the General Practitioner in the Management of Vesical Neck Obstruction"**

FREDERICK E. B. FOLEY, M.D., St. Paul, Minnesota

Associate Professor of Urology, University of Minnesota Medical School, Minneapolis; Chief Urologist, Ancker Hospital, St. Paul; Visiting Urologist, Charles T. Miller Hospital, St. Paul.

When a patient presents himself with urinary symptoms, the general practitioner can and should promptly find the answers to the following questions:

1. Is the trouble due to vesical neck obstruction?
2. What type of vesical neck obstruction is present?
3. Is surgical treatment required at once?
4. May palliative treatment be employed safely with postponement of operation?
5. Is the patient ready for immediate operation or will he be made a better surgical risk by pre-operative treatment directed by the general practitioner?

The part of the general practitioner finding the answers to these questions is presented.

9:50 **"Management of the Failing Heart"**

HARRY GOLD, M.D., New York City

Associate Professor of Pharmacology at Cornell University Medical School; Attending Cardiologist at the Beth Israel Hospital and at the Hospital for Joint Diseases, N. Y.

A group of nearly 100 patients with advanced heart failure admitted routinely to each of three hospitals were managed in the following way: a quart of milk daily as the sole diet; two to three quarts of water daily; single dose digitalization; a daily intramuscular dose of a mercurial; daily body weight. The time it took to produce the dry weight with maximum relief in this group was compared with that in approximately 400 similar cases treated in four large hospitals of New York by the customary methods in vogue in the past ten years which involved fractional digitalization, water restriction, so-called salt free diets, oral diuretics, and irregular doses of the mercurial. The period from admission to maximum improvement was an average of about three weeks by the latter method, as compared to somewhat less than one week by the former method.

The paper suggests the routine use of this intensive regime for the control of heart failure and presents the physiological basis in support of the method.

10:10-11:10 **INTERMISSION TO VIEW EXHIBITS**

11:10 **"Chronic Arthritis"**

RUSSELL L. CECIL, New York City

Professor of Clinical Medicine, Cornell Univerity Medical College, New York City; Visiting Physician, Bellevue Hospital, New York City; Consulting Physician, New York and Veterans' Hospitals, New York City.

Arthritis occurs in a variety of different forms depending on the etiology. The two dominant types are osteoarthritis and rheumatoid arthritis. Osteoarthritis is a disease of wear and tear, seen most frequently in middle-aged and elderly patients and responds well to rest, physiotherapy and orthopedic measures. The rheumatoid type presents a more difficult problem, partly because of the uncertainty associated with its etiology. Much present-day evidence points toward its resting upon an allergic base. The important features in the treatment of rheumatoid arthritis are rest, physiotherapy, regulation of diet and vitamins, treatment with gold salts and blood transfusions, climatotherapy and psychotherapy.

11:30 "Surgery of the Spleen"

GEORGE M. CURTIS, M.D., Columbus, Ohio
Professor of Surgery at the Ohio State University.

The surgery of the spleen develops best in the background of sound physiologic hematology. The spleen may sequestrate the various blood cells or destroy them by its hemolytic powers. If this process becomes pathologic, splenectomy may be indicated. Recurrence of congenital hemolytic icterus or of thrombopenic purpura, the two commonest indications for splenectomy, is usually due to the presence of an accessory spleen. The significance of emergency splenectomy and of accessory splenectomy will be discussed. Splenectomy is indicated in traumatic rupture of the spleen. No ill effects have been found to follow removal of the ruptured normal spleen in children.

11:50 End of Second General Assembly

INTERMISSION TO VIEW EXHIBITS

Program of Sections

WEDNESDAY NOON
September 24, 1947

12:00 to 1:30 p.m. (luncheon)

SECTION ON UROLOGY

Room 322, Pantlind Hotel

Chairman: R. K. RATLIFF, M.D., Ann Arbor
Secretary: H. L. MILLER, M.D., Detroit

"An Artificial Sphincter. A New Device and Operation for Control of Urinary Incontinence and Nocturnal Enuresis."

FREDERIC E. B. FOLEY, M.D., Saint Paul, Minnesota.

Operations for cure of urinary incontinence in the male generally are not successful. Previous means of controlling or caring for incontinence have been makeshifts and far from satisfactory. The new operation permits use of a pneumatic incontinence clamp which is essentially automatic. It does not cause partial erection or other discomfort and is free of the objections to previous means of caring for incontinence. It permits apparently normal urination.

* * *

SECTION ON PEDIATRICS

Sadler Lounge, Pantlind Hotel

Chairman: M. F. OSTERLIN, M.D., Traverse City
Secretary: J. H. LEWIS, M.D., Wyandotte

"Management of Infantile Congenital Syphilis"

R. V. PLATOU, M.D., New Orleans, Louisiana

Recent extensive experiences justify the impression that penicillin, in currently recommended dosage schedules, is the single agent for treatment of infantile congenital syphilis. Immediate effects are gratifying, therapeutic reactions are transient and unimportant, and follow-up studies have demonstrated increasingly satisfactory results.

A scientific exhibit and discussion will summarize diagnostc features and will compare effects of therapy in treated infants with those in previously untreated patients of similar age. Though the widespread practice of employing massive penicillin therapy for febrile diseases of uncertain etiology may mask many protean features of congenital syphilis, and thus increase practical difficulties in interpretation of routine serologic tests, it will probably also have considerable effect in further reducing the incidence of this disease.

SECTION ON SURGERY

Ballroom, Pantlind Hotel

Chairman: J. C. FOSHEE, M.D., Grand Rapids
Secretary: EDWARD DOWDLE, M.D., Detroit

"Importance of Preoperative and Postoperative Care in Intestinal Surgery"

CLAUD F. DIXON, M.D., Rochester, Minnesota
GEORGE M. CURTIS, M.D., Columbus, Ohio (Discussant)

* * *

SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

Room 222, Pantlind Hotel

Chairman: (Oto.) JAMES MAXWELL, M.D., Ann Arbor
Co-Chairman: (Ophth.) RALPH GILBERT, M.D., Grand Rapids

* * *

OTOLARYNGOLOGICAL PROGRAM

Secretary: (Oto.) J. L. DILL, M.D., Detroit
Co-Secretary: (Ophth.) WALTER RUNDLES, M.D., Flint

"The Significance of Postural Vertigo in Otoneurological Diagnosis."

JOHN R. LINDSEY, M.D., Chicago

WEDNESDAY AFTERNOON
September 24, 1947

Third General Assembly

Black and Silver Ballroom, Civic Auditorium

P. A. RILEY, M.D., Jackson, *Presiding*
L. FERNALD FOSTER, M.D., Bay City and R. B. KENNEDY, M.D., Detroit, *Secretaries*

P.M.
1:40 **"Certain Aspects of Vaginal Surgery"**

ARCHIBALD D. CAMPBELL, M.D., Montreal, Canada
Associate Professor of Obstetrics and Gynecology, McGill University, Montreal; Gynecologist-in-Chief, The Montreal General Hospital.

Vaginal surgical procedures are undertaken mainly for the reconstruction of the structures damaged by childbirth, the correction of congenital defects, or the removal of certain pathological lesions.

The anatomy of the pelvic basin, with particular reference to those structures which retain the topography of the pelvic viscera, is briefly reviewed.

The importance of a proper conduct of labor is emphasized, and its bearing on subsequent degrees of birth trauma are stressed. The basic principles involved in the repair of complete tear and procidentia are outlined.

2:00 **"Vertigo, Differential Diagnosis and Treatment"**

JOHN R. LINDSAY, M.D., Chicago
Professor of Otolaryngology, the University of Chicago.

Vertigo or dizziness arising from the inner ear, eighth nerve or vestibular pathways in the brain is usually divided into two clinical groups. Ménière's syndrome and pseudo-Ménière's syndrome.

"Ménière's syndrome" commonly includes all types of inner ear or eighth nerve diseases excepting labyrinthitis, tumor and fracture. Several diseases or causes for the syndrome may be differentiated.

"Ménière's Disease" or "labyrinthine dropsy" is the most common cause of Ménière's syndrome. The diagnostic features and pathologic pictures will be reviewed and the treatment discussed.

Pseudo-Ménière's syndrome is the term usually applied to attacks of vertigo not associated with auditory symptoms.

The localization and differential diagnosis will be discussed and the treatment for the various etiologic conditions reviewed.

2:20 "The Tuberculous Child"

R. V. Platou, M.D., New Orleans

Professor of Pediatrics and Head of Department of Pediatrics, Tulane University School of Medicine, New Orleans, Louisiana.

Techniques familiar to all physicians render discovery of tuberculosis in children a relatively simple process. Given a positive tuberculin reaction, however, the physician assumes five distinct responsibilities: To determine (1) *source* of exposure or contacts, (2) *duration* of the tuberculous process, (3) careful evaluation of opportunities for *reinfection* in the child's present environment, (4) *localization* and extent of *activity* in any recognizable focus, and (5) infectious nature of demonstrable primary or secondary lesions.

The virtues of routine tuberculin tests among children seem well established, but follow-up studies are often incomplete or unsatisfactory. Confusion in conventional terminology is partially responsible for this faultiness; revisions based on sound objective criteria should be useful and might improve current programs for control or eradication of tuberculosis.

2:45-3:45 INTERMISSION TO VIEW EXHIBITS

3:45 "The Physician and the Child"

Reynold A. Jensen, M.D., Minneapolis

Associate Professor of Pediatrics and Psychiatry, University of Minnesota.

The doctor has long had an active interest in the growth, development and general welfare of the child. Much has been done to better understand and provide more adequately for the child's physical needs. However, with newer developments coming along it becomes clear that psychological and emotional factors require greater consideration than appreciated previously. This paper will briefly consider these needs and indicate what we, as doctors, might do in meeting them.

4:05 "Carcinoma of the Colon and its Management"

Claude F. Dixon, M.D., Rochester, Minnesota

4:25 End of Third General Assembly

4:30 DISCUSSION CONFERENCES IN MEDICINE, SURGERY, UROLOGY, PEDIATRICS, OTOLARYNGOLOGY, GYNECOLOGY, AND GENERAL PRACTICE (See Page 950)

WEDNESDAY EVENING
September 24, 1947

Fourth General Assembly

Black and Silver Ballroom, Civic Auditorium

Wm. A. Hyland, M.D., Grand Rapids, *Presiding*

L. Fernald Foster, M.D., Bay City, *Secretary*

P.M.

8:30 Officers' Night—Public Meeting

1. Call to order by President Wm. A. Hyland, M.D., Grand Rapids.
2. Announcements and Reports of the House of Delegates by Secretary L. Fernald Foster, M.D., Bay City.
3. President's Annual Address—Wm. A. Hyland, M.D., Grand Rapids.
4. Induction of P. L. Ledwidge, M.D., Detroit, into office as President of the Michigan State Medical Society by the Retiring President.
   Response.
5. Introduction by the Retiring President of the President-Elect and other newly elected officers and of the Chairman of The Council of the State Society.
6. Presentation of Scroll and Past-President's Key to Dr. Hyland by the Chairman of The Council, E. F. Sladek, M.D., Traverse City.

9:00 7. The Andrew P. Biddle Oration

"Atomic Radiation and Its Medical Implications"

Rear Admiral C. A. Swanson, M.C., USN, The Surgeon General, Washington, D. C.

8. Presentation of Biddle Oration Scroll

The late
Andrew P. Biddle, M.D.
Patron of Postgraduate Medical Education
(Deceased August 2, 1944)

9. End of Fourth General Assembly

THURSDAY MORNING
September 25, 1947

Fifth General Assembly

Black and Silver Ballroom, Civic Auditorium

A. H. Miller, M.D., Gladstone, *Presiding*

L. Fernald Foster, M.D., Bay City and E. C. Texter, M.D., Detroit, *Secretaries*

A.M.

9:30 **"Comparison of Chemical and Physical Methods of Treating Thyrotoxicosis"**

Robert H. Williams, M.D., Boston

Assistant Professor Harvard Medical School.

Now that it has been shown that anti-thyroid chemicals and radioactive iodine can produce permanent remission of thyrotoxicosis, the problem has arisen as to the place of each when considering the large masses of such cases throughout the country.

Of the thiouracils, the propyl derivative is one of the best. It is effective in controlling most of the patients and it has rarely cause significant toxic reactions.

Radioactive iodine is very useful in some of the cases, especially complicated ones.

Thyroidectomy still is indicated in selected cases, particularly the ones with large nodular goiters.

No ideal treatment for thyrotoxicosis has been found, but search should continue in this direction.

9:50 **"Senile Cataract from the Standpoint of the General Practitioner."**

C. S. O'Brien, M.D., Iowa City, Iowa

Professor and Head, Department of Ophthalmology, College of Medicine, State University of Iowa; Chief of Clinic, University Hospitals.

The family physician should have some knowledge of senile cataract since it is he to whom the patient first goes for advice. The doctor should be able to make a diagnosis and to differentiate certain other diseases which cause gradual faliure of vision in elderly people, e.g., an improper diagnosis of cataract in a patient with chronic glaucoma is usually a sentence to blindness. Drugs are of no value and surgical removal of the cataractous lens is the only satisfactory treatment. It is unnecessary to await ripening of the cataract. The operation is made when the patient's vision in the better eye becomes inadequate for work or pleasure.

10:10-11:10 **INTERMISSION TO VIEW EXHIBITS**

11:10 **"The Diagnosis and Treatment of Ectopic Pregnancy"**

Frank E. Whitacre, M.D., Memphis

Chief of The Division of Obstetrics and Gynecology, University of Tennessee, College of Medicine and Director of Medical Services, Department of Obstetrics and Gynecology, John Gaston Hospital, Memphis.

Any bleeding during pregnancy must be considered abnormal. Regardless of the stage of gestation, obstetric bleeding originates from the same anatomical location—that is a separation of the spongy layer of the decidua, whether associated with the placenta or not, exposing maternal sinuses.

The diagnosis of ectopic pregnancy is confused with that of recent or remote pelvic inflammatory disease and intra-uterine abortion. Methods of diagnosis are described, including the technique of cul-de-sac aspiration. Laboratory and clinical evidence suggests that the detection of hematin in the blood stream is useful in establishing the presence or absence of intra-abdominal hemorrhage. A few tubal pregnancies continue to become secondary abdominal pregnancies. We have recently reported twelve such cases. The treatment of ectopic pregnancy early or late is emphasized.

11:30 **"Therapeutic Application of Hemometakinesia in Peripheral Vascular Disturbances"**

Michael E. DeBakey, M.D., New Orleans, La.

Associate Professor of Surgery, Department of Surgery, School of Medicine, Tulane University of Louisiana and Associate in Surgery, The Ochsner Clinic.

The primary goal in peripheral vascular disease is an increase in the blood supply of the part. Various measures have been proposed to achieve this objective, but in our experience the most rational and effective approach is one based upon a concept of hemodynamics, for which the term hemometakinesia has been proposed. The essential feature of this mechanism of hemodynamics seems to consist in the control and regulation of the vascular bed, which permits an increase in the volume of blood of one part of the body with a corresponding simultaneous decrease in the volume of blood in other parts, without material alteration in the total blood volume or cardiac output. This presentation is concerned with an elaboration of this concept and its therapeutic applications.

11:50 **End of Fifth General Assembly**

INTERMISSION TO VIEW EXHIBITS

Program of Sections

THURSDAY NOON
Sept. 25, 1947,

12:00 to 1:30 p.m. (luncheons)

SECTION ON MEDICINE

Furniture Club, Pantlind Hotel, (Mezzanine floor, behind elevators and to the West)

Chairman: F. W. Baske, M.D., Flint

Secretary: G. T. McKean, M.D., Detroit

"Recent Developments in the Management of Peptic Ulcer"

Herman M. Pollard, M.D., Ann Arbor

Associate Professor of Internal Medicine, University of Michigan.

There have been several recent contributions to the therapy of peptic ulcer which offer considerable hope to the management of this disease. Sufficient time has elapsed since the introduction of these measures to make an evaluation of their effectiveness. The two most prominent of these measures include section of the vagus nerves and the use of hormones, such as enterogastrone. The indications for vagotomy will be discussed including immediate and follow-up results in patients so treated. The mechanism for the use of enterogastrone will be mentioned briefly plus our own experience with this hormone in the actual treatment of ulcer patients.

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SECTION ON OPHTHALMOLOGY AND OTOLARYNGOLOGY

Room 222, Pantlind Hotel (Second floor behind elevators and to the West)

Chairman: (Oto.) James Maxwell, M.D., Ann Arbor

Co-Chairman: (Ophth.) Ralph Gilbert, M.D., Grand Rapids

Secretary: (Oto.) J. L. Dill, M.D., Detroit

Co-Secretary: (Ophth.) Walter Rundles, M.D., Flint

OPHTHALMOLOGICAL PROGRAM

"Surgery of the Extraocular Muscles"

C. S. O'Brien, M.D., Iowa City, Iowa

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SECTION ON RADIOLOGY, PATHOLOGY, AND ANESTHESIA

Chairman: (Path.) S. E. Gould, M.D., Eloise

Secretary: (Rad.) J. E. Lofstrom, M.D., Detroit

Secretary: (Anes.) H. J. VanBelois, M.D., Grand Rapids

ANESTHESIOLOGICAL PROGRAM

Discussion Conference: "Economic Problems in Anesthesiology"

Leader: R. J. Armstrong, M.D., Kalamazoo

Chief of Anesthesia Service, Bronson Methodist Hospital and Borgess Hospital, Kalamazoo.

A summary of data on anesthetic fees will be presented. Fee schedules of all voluntary prepayment medical plans in U nited States have been analyzed as well as Veterans Administration fee schedules and those of private anesthesiologists in Michigan. An effort will he made to interest especially the incidental medical anesthetist in Michigan on what patient and surgeon feel are equitable fees for competent anesthesia. An attempt will be made to interest all physicians doing anesthesia so that the time of the meeting will he devoted chiefly to a discussion of mutual problems rather than a formal presentation by the essayist.

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SECTION ON GYNECOLOGY AND OBSTETRICS

Schubert Room, Pantlind Hotel, (southwest corner of hotel, use corridor from lobby)

Chairman: R. B. Kennedy, M.D., Detroit
Secretary: H. H. Lampman, M.D., Detroit

"Changing Trends in Cesarean Section"

Harold C. Mack, M.D., Detroit

* * *

SECTION ON GENERAL PRACTICE

Ballroom, Pantlind Hotel (west of lobby—up grand staircase)

Chairman: E. C. Texter, M.D., Detroit
Secretary: E. M. Pettis, M.D., Muskegon

"Unusual Forms of Rheumatic Pain"

Russell L. Cecil, M.D., New York City

Rheumatic pain can occur in either the joints or the muscles. It should never be confused with neuritic pain which is due entirely to irritation of a nerve. The majority of joint pains are referahle to some form of arthritis but there is a large minority which fall into the category of arthralgia. Many but not all of the arthralgias are psychogenic in origin. Another large group are definitely associated with menopause. A third group can be traced to some occupation or sport. Muscular pains are frequently due to actual infiltration of the muscle hundles with round cells. Such forms of myositic pain are seen in dermatomyositis, lupus, periarteritis nodosa and rheumatoid arthritis. Muscular pain, however, can also be traced to other causes such as menopause, occupation or psychoneurosis. The treatment of joint pains as well as muscle pains consists of eliminating the cause if possible and the application of physiotherapy, massage, and other more specific measures.

THURSDAY AFTERNOON
September 25, 1947

Sixth General Assembly

Black and Silver Ballroom, Civic Auditorium

R. J. Hubbell, M.D., Kalamazoo, *Presiding*
L. Fernald Foster, M.D., Bay City and Ralph Gilbert, M.D., Grand Rapids, *Secretaries*

P.M.

1:40 **"The Use of Penicillin in the Treatment of Syphilis in General Practice"**

Paul A. O'Leary, M.D., Rochester, Minn.

Head of the Section on Dermatology and Syphilology, Mayo Clinic Rochester, Minnesota, and Professor of Dermatology, Mayo Foundation, University of Minnesota.

Experience with penicillin in hundreds of thousands of cases has demonstrated its value. Results in the prevention of congenital syphilis are outstanding, as are the results in certain types of visceral syphilis. Our knowledge of its value in early syphilis is in the process of forming, although it would seem that in the late form of the disease, especially neurosyphilis, the results are below expectations. Experience in changing the time-dose relationships is improving results in the treatment of early syphilis.

2:00 **"The Treatment of Infantile Diarrhea"**

L. Emmett Holt, Jr., M.D., New York City

Professor of Pediatrics at New York University and Director of the Children's Medical Service of Bellevue Hospital

The traditional therapy of "starving a diarrhea" in an infant in order to rest the intestine and permit functional recovery has heen submitted to a systematic chemical study. The results of this study, carried out in collaboration with Dr. Arthur Chung, will he described in detail. They fail to support the time honored regime of oral starvation and indicate that in infantile diarrhea, as in typhoid fever, the patient should be fed from the start, the amount given being limited only by the gastric tolerance.

2:20 **"Gout"**

Russell L. Haden, M.D., Cleveland

Chief of Medical Division of the Cleveland Clinic.

Gout is the most commonly overlooked diagnosis in the consideration of joint disease. The clinical picture is varied. The characteristic history is an acute, very painful arthritis of acute onset with a complete return of the joints to normal between attacks. In many patients, the findings are very atypical.

The diagnosis and treatment will be discussed.

2:45-3:45 **INTERMISSION TO VIEW EXHIBITS**

3:45 **"The Role of BCG Vaccine in the Control of Tuberculosis"**

Joseph D. Aronson, M.D., Philadelphia

Associate Professor of Bacteriology, Henry Phipps Institution, University of Pennsylvania.

The effectiveness of BCG vaccine (B. Calmette-Guerin) as a prophylactic measure against tuherculosis was studied under control conditions. Since 1936, groups of Indians living in various parts of the United States and Alaska, who were tuberculin negative, were vaccinated intracutaneously with freshly prepared BCG vaccine. Comparable numbers of tuberculin negative individuals received physiological salt solution and served as controls. Both groups continued to live under their normal conditions. Roentgenological examination of the chest and tuberculin tests of hoth groups were carried out at periódic intervals. The results after 11 years of observation indicate a markedly lower mortality from tuberculosis among the vaccinated and a persistence of the tuberculin reaction during the period of observation.

4:05 **"Cancer of the Breast"**

Stuart W. Harrington, M.D., Rochester, Minnesota

Head of section of Thoracic and General Surgery at Mayo Clinic; Professor of surgery, Mayo Foundation, University of Minnesota.

Early clinical recognition and immediate surgical treatment are the most important considerations of malignant disease of the breast. The results following surgical treatment have been markedly improved by radical mastectomy. Since the introduction of this method of treatment hy Halstead, it has been the method most generally accepted by the medical profession.

There are many factors which influence the results of surgical treatment. Some of the more important of these factors are as follows: (1) the extent of the malignant involvement at the time of operation, (2) the thoroughness with which the radical operation is done, (3) the degree of malignancy as shown by microscopic examination of the primary lesion, (4) the presence of other associated conditions such as pregnancy, (5) the general constitutional diseases such as diabetes, and (6) the age of the patient.

This study shows the three, five, ten, fifteen and twenty year results and the various factors which influence the results in a series of 6,149 patients treated by radical mastetcomy.

4:25 End of Sixth Assembly

4:30 DISCUSSION CONFERENCES IN MEDICINE, SURGERY, ANESTHESIA, OPHTHALMOLOGY, GYNECOLOGY-OBSTETRICS, GENERAL PRACTICE, PEDIATRICS AND SYPHILOLGY. (See page 950)

THURSDAY EVENING
September 25, 1947

10:00 P.M. STATE SOCIETY NIGHT
An evening of entertainment for MSMS members, their ladies and guests. Dancing and floor show. Ballroom, Pantlind Hotel
(Admission by card)

FRIDAY MORNING
September 26, 1947

Seventh General Assembly

Black and Silver Ballroom, Civic Auditorium

R. H. Holmes, M.D., Muskegon, *Presiding*
L. Fernald Foster, M.D., Bay City and S. E. Gould, M.D., Eloise, *Secretaries*

A.M.
9:30 "The Potentialities and Limitations of Prenatal Pediatrics"

Clement A. Smith, M.D., Boston

Assistant Professor of Pediatrics, Harvard Medical School; Director of Research on The Newborn Infant, Boston, Lying-in Hospital; Consulting Physician, Massachusetts General Hospital; Physician Children's and Infants' Hospital, Boston.

The title indicates a real possibility of influencing the healtb and survival of the child before birth. Available data indicate that the size and maturity of the baby when born, the integrity of its development, and the degree of its ability to resist infections in early postnatal life, can all to a certain degree be influenced by medical procedures carried on during the pre-natal period. It is also possible to cure at least one important fetal disease by drug therapy before birth. Still other conditions affecting the fetus and newborn infant are prenatally preventable. How the medical profession should apply these facts, and to what degree we can expect to be successful, are discussed in this paper.

9:50 "When and Why Should the State Compel the Performance of an Official Autopsy?"

Alan R. Moritz, M.D., Boston

Professor of Legal Medicine, Harvard Medical School; Expert Assistant (Medico-Legal Consultant), Massachusetts Department of Public Safety; Lecturer in Legal Medicine, Boston University School of Medicine and Tufts Medical School; Consulting Pathologist, Massachusetts Department of Mental Health; Consulting Pathologist, Peter Bent Brigham Hospital.

It is obvious that the importance to medical education and research of information gained at the postmortem table through the efforts of skilled hospital pathologists has long been recognized in Michigan. It is equally obvious that cognizance has not been taken of the potential benefits to public safety and health tbat could be derived if the bodies of persons who die outside of hospitals from violence or suddenly from obscure causes were examined with equal competence.

The information derived from medicolegal autopsies is often of direct and immediate importance in distinguishing between accident, homicide and suicide. It often determines whether or not a murderer will be convicted, an innocent person prosecuted, a claim for damages substantiated, or an unsuspected hazard to public health recognized. The medical profession of Michigan can ill afford to ignore the need for legislative change which will provide for competent investigation of deaths due to violent and obscure causes.

10:10-11:10 INTERMISSION TO VIEW EXHIBITS

11:10 "Closure of Abdominal Fistula"
W. Wayne Babcock, M.D., Philadelphia

Professor of Surgery and Clinical Surgery, Temple University; Surgeon-in-Chief, Temple University Hospital; Surgeon, Philadelphia General Hospital, Philadelphia.

11:30 "The Present Status of Sulfonamide and Antibiotic Therapy"
Wallace E. Herrell, M.D., Rochester, Minnesota

Consultant in Medicine, Mayo Clinic, Assistant Professor in Medicine, Mayo Foundation Graduate School, University of Minnesota.

This discussion deals with the present status of sulfonamide therapy. The present status of antibiotic therapy with particular reference to the use of penicillin and streptomycin also will be discussed. The selective action of these agents as well as methods of administration, dosage and toxicity is included in the discussion.

11:50 End of Seventh General Assembly

INTERMISSION TO VIEW EXHIBITS

Program of Sections

FRIDAY NOON
September 26, 1947

SECTION ON RADIOLOGY, PATHOLOGY, AND ANESTHESIA

Room 222, Pantlind Hotel (second floor behind elevators and to the west)

Chairman: (Path.) S. E. Gould, M.D., Eloise
Secretary: (Rad.) J. E. Lofstrom, M. D., Detroit
Secretary: (Anes.) H. J. VanBelois, M.D., Grand Rapids

PATHOLOGICAL PROGRAM

"The Doctor in Court"
F. Roland Allaben, A.B., LL.B.

City Attorney, Grand Rapids, Commissioner, State Bar of Michigan.

"The Doctor in Court" will present some practical suggestions to physicians as to court procedure and their manner of delivering testimony when called as a witness.

Discussant: Alan R. Moritz, M.D., Boston

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12:00 NOON (LUNCHEONS)
DISCUSSION CONFERENCES IN MEDICINE, PEDIATRICS, and SURGERY (See page 950).

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END OF SCIENTIFIC ASSEMBLY AND OF 1947 ANNUAL SESSION

Annual Reports

ANNUAL REPORT OF THE COUNCIL, 1946-47

The Council convened three times and the Executive Committee met nine times (to September 20, 1947), a total of twelve meetings up to the 1947 Session of the State Society. All matters studied and recommendations made by the Society's twenty-seven Committees as well as The Council's own twenty-six Committees and all business of the Society were referred to The Council or its Executive Committee for consideration, approval, and action.

Membership

Members of the State Society as of July 1 and as of December 31, from 1935 to 1947, are indicated in the following chart:

	1947	1946	1945	1943	1941	1939	1935
July 1	4536	4461	4425	4661	4403	4255	3410
December 31		4799	4686	4786	4621	4425	3653

The figure for 1947 includes 4,263 active members, 143 Emeritus, Retired, and other special members, and 130 Military Members. The Society is continuing its wartime practice of according full membership privileges, with remission of dues and assessment, to members in military service; this applies to all members separated from military service during 1947.

Finances

The report of Ernst & Ernst on the annual audit of the MSMS books for 1946 shows the financial condition of the Society to be sound. The investments of the Society are all in government and other high grade bonds which are stable in value but show a reasonable return on the investment. All MSMS members are invited to study the auditors' report for 1946, published in full in the March, 1947 issue of The Journal beginning on page 339, together with the budget estimates for 1947, appearing on the same page.

The total paid membership on July 1, 1947 of 4,263 compares with 3,033 on the same date in 1946; the increase represents our former military members who have returned to dues-paying status this year. The greater income from dues and assessments has permitted us to augment the Society's activities.

The number of special members was considerably increased in 1946 by the election of 55 Life Members, 21 Emeritus Members, 5 Retired Members, and 1 Associate Member, bringing the total special membership roster to 143. This costs the Society in loss of income a total of $5,291.00 per annum.

The House of Delegates at the 1946 annual session continued the special assessment which has been used to finance the very active, intensive and pioneering public relations and education program of the Society. This worth-while and necessary work has become well known through the state and nation and has brought renown to the Michigan State Medical Society. It would seem desirable to insure that our very beneficial public relations activity is made a continuing program throughout the years. To provide for exigencies, the Executive Committee of The Council in February, 1947, placed $30,000 of current income from the twenty-five dollar assessment in savings accounts earmarked for Public Relations.

A recommendation on continuation of the Public Relations program follows. The crowded condition at 2020 Olds Tower, Lansing, is critical and is seriously affecting top efficiency in our hardworking Executive Office staff. Since it appears impossible to procure additional space in the Olds Tower or in any other Lansing office building at this time, the Finance Committee feels that the securing of a house or a small building by the Michigan State Medical Society should be promptly investigated.

The Journal

The Journal has again had a very active and successful year. Under the direction of the Publication Committee we have constantly striven to make The Journal of increasing interest to the readers. "You have been putting out a very interesting and instructive Journal, but there is too much advertising." That was the comment of a friend just the other day, and is being repeated frequently. We were stimulated to check on the contents and find that the May number of The Journal, the last one at hand, contained seventy-three pages of advertising as against eighty-eight last year. In addition, there were five pages devoted to State Society material, title, committees, contents, et cetera; twenty-nine pages of original scientific articles, and nineteen pages devoted to editorials and editorial material, comments, various reports, news, and articles on economic or organizational affairs. That makes sixty-three pages of text and interest material.

The income from advertising has fallen off because of our adopting the policies of the CMAB and the AMA Councils. Fifteen pages of advertising a month represents a decided loss of revenue, but the Editor has also cut down by about eight pages the amount of medico-sociological and economic material.

We believe we have still given the membership what is most interesting and valuable in our contest with political medicine and the trend toward socialism of the profession. Politics has changed the immediate threat, but only in that the danger is more hidden. The socializers are still in the employ of government and are working harder than ever.

We believe we have improved the appearance of The Journal. The editorial policy has been aggressive, and will continue so. We have continued to publish articles on Political Medicine, Rehabilitation of Veterans and Veteran Medical Officers, Medical Public Relations, Conferences of Presidents, Michigan Medical Service, National Health Conference, Conferences of Deans at Ann Arbor, et cetera. This policy will be continued as need arises.

Due to a strike, shortage of materials and workers, and to the use of color in advertising, The Journal is still appearing late, but we have greater hopes of again making the publication date approximately the correct date. We have gained a week lately, and have promise of improvement in the near future.

The Publication Committee is always open to suggestions for improving The Journal, and wishes to know the desires of the readers. Improvement in material available, and the resumption of conferences and meetings give promise of a still more valuable Journal.

Organization

Organization in all component county medical societies is now up to its prewar status. Many county societies are offering outstanding postgraduate opportunities to their members, some featuring an annual "clinic day" with programs on a par with a national meeting. The economic phases of county society activities have been improved vastly since the war which tended to impress on more and more individual practitioners the flaws of a socialized system of medicine.

Roy Herbert Holmes, M.D., Muskegon, was appointed Councilor of the Eleventh District on July 10, 1947, to fill the vacancy caused by the resignation of O. D. Stryker, M.D., who moved to another District.

Meetings in six Councilor Districts were held during the winter and spring of 1947, at Flint, January 14, 1947, Marlette, March 20, Detroit, March 31, Grand Rapids, May 13, Sault Ste. Marie, June 25, and at the Gateway (Upper Peninsula) June 26. Your MSMS Officers and members of The Council attended these District meetings and spoke on such subjects as: "Medical Matters in Michigan;" "Rural Health and General Practice;" "The Federal Hospital Construction Program;" "State Legislation in 1947" and "Modern Medical Public Relations." Numerous county society meetings were attended by MSMS Councilors and Officers throughout the year.

The County Secretaries-Public Relations Conference of February 2, 1947 at the Book-Cadillac Hotel, Detroit, attracted an interested group of county society secretaries, legislative and public relations keymen, and representatives of the Woman's Auxiliary. Topics important to Medicine were presented by: Governor Kim Sigler; Gene Alleman, East Lansing; Grace Mooney, Ph.D., New Haven, Connecticut; Les Biederman, Traverse City; Arthur L. Conrad, Washington, D. C.; Frank G. Dickinson, Ph.D., Chicago; L. S. Kleinschmidt, Chicago, and H. W. Brenneman, Lansing.

At the American Medical Association Centennial in Atlantic City the week of June 9, an outstanding piece of public relations coverage was done by Michigan's representatives. The five MSMS Delegates performed outstanding service in the AMA House of Delegates and forwarded the interests of medical practitioners in our State: an enviable position in the national organization has been secured over the years by Michigan's progressive Delegates whose words now carry weight.

Valuable contacts among AMA officials and in ancilliary groups were made by other officers of the Michigan State Medical Society who attended the AMA; their continued presence at these Annual Sessions and their progressive recommendations and wise judgment on national medical problems have resulted in an assumption of leadership in such activities, as the: (a) Associated State Postgraduate Committees; (b) Program Committee, National Conference on Medical Service; (c) Co-operative Medical Advertising Bureau; (d) AMA Conference of County Society Officers; (e) Conference of Presidents and Other Officers of State Medical Associations; (f) Medical Society Executives Conference; (g) Medical Exhibitors Association; (h) Numerous informal meetings with individual officers of State Societies for the interchange of valuable information along medico-organizational lines.

Michigan continues to maintain its position of leadership, thanks to the self-sacrificing contribution of time and effort on the part of its MSMS Officers and Delegates who hold office or have achieved roles of guidance in national organizations and activities.

Accelerated Public Relations Program

"Full steam ahead" aptly describes the MSMS Public Relations Program of the past twelve months. A bird's eye view of the multitudinous activities of the P. R. Committee and its Counsel, Hugh W. Brenneman, best indicates the scope of work of this aggressive group whose program—scanned with interest and emulated by many other state medical societies—is possibly only through the generous financial contribution of every member of the Michigan State Medical Society. The panorama of activity of our Public Relations Committee is more fully appreciated by outlining some of the sub-titles:

Newspaper advertising—see P. R. Plan Supplement No. 1, sent to all MSMS members in June, 1947.

Radio program—see P. R. Plan Supplement No. 2, published in July, 1947. Total number of radio 60-minute hours: 372; total number of radio programs per annum: 3,861.

News releases—to all Michigan newspapers, on a bimonthly basis.

Development of booklets and printed material (kits for M.D. speakers, high school and college debaters) showing benefits of American Medicine and private practice aided by voluntary pre-paid service plans.

Public Relations Bulletins to P. R. keymen throughout the State—inaugurated October, 1946.

Health education in schools, highlighted by program of venereal disease control.

Health news columns weekly in 157 county newspapers.

Articles in The Michigan Farmer.

"Medical Plan of Michigan"—an over-all "bible" listing the varied activities of the Michigan State Medical Society—a reference book for newspaper editors, radio writers, physicians, et cetera (published and mailed to all MSMS members in September, 1947).

Committee on Awards, created as a public relations vehicle whereby a county or the State Medical Society may honor outstanding laymen for accomplishments in the field of health.

Exhibits for the public, such as in the windows of business establishments in Grand Rapids during 1947 MSMS Annual Session.

Legislative Contacts, both in Lansing and in Washington, D. C. (including hearings on the Taft Health Bill—S.545).

Michigan Rural Health Conference, a joint venture sponsored by the Michigan State Medical Society in cooperation with 25 other agencies, scheduled for Michigan State College, East Lansing, September 18-19, 1947.

Michigan Rural Survey, sponsored by the Michigan State Medical Society, Michigan State College, and the Michigan Foundation for Medical and Health Education and other agencies—a three-year project to indicate the adequacy of medical care in Michigan's rural areas, to which MSMS contributed $5,000 as its share of the total expense of $45,000.

Contacts with the laity through medical talks to fraternal, civic, service, and veterans' organizations.

Contacts with newspapermen and radio broadcasters in their own community.

Close integration with other organizations in the health field.

To help handle the many details of the newspaper advertising and radio programs, both of which have attained adult proportions, the Michigan State Medical Society enlisted the services of an advertising agency during the yast year, with excellent results.

The Public Relations Counsel successfully organized an informal conference of state and county medical society public relations counsels which held its initial meeting in Chicago on February 8, 1947, with an attendance of 37 individuals from all sections of the country. The pioneering work in Michigan was readily recognized by representatives of other medical organizations which, during the year, have called upon the MSMS for aid and advice, including informational talks at neighboring and distant state public relations conferences—which aid has always been forthcoming from the Michigan State Medical Society. The commanding position among state medical societies which Michigan enjoys is due to its courage, within recent years, to experiment and try out plans and programs for the benefit of its members and those whom they serve. This has required organization and finances, both of which have been supplied generously by the MSMS membership.

Committees

A total of 53 Committees functioned during the past year to aid The Council and the membership in the study of all matters and current problems facing the medical profession during the parlous period of postwar

adjustment. The accomplishments of these very active groups are portrayed in their splendid Annual Reports, published in the Handbook for Delegates. The progress of the Michigan State Medical Society is molded by its productive committees whose members deserve high praise and sincere gratitude for their time-consuming efforts in behalf of all medical practitioners of Michigan. Some of the more active Committees included:

1. The Committee on Scientific Work has arranged a high calibre program for the 1947 Annual Session in Grand Rapids. Those who attend this three-day postgraduate course will have best evidence of the many months of preparation spent by this active Committtee.

2. The Public Relations Committee—the achievements of this very active Committee, and of its several advisory committees, are fully outlined in its Annual Report (see page—). Chairman J. S. DeTar, M.D., merits the thanks of the Michigan State Medical Society and of all its individual members for his untiring efforts in helping to make successful the ambitious program of the Public Relations Committee during the past twelve months.

3. The augmented Cancer Control Committee, aided by funds from the Michigan State Medical Society, from the American Cancer Society, Michigan Division, as well as from the Michigan Department of Health, has accomplished more in a few months by a unified program than was possible through years of individual effort by three separate groups, though all were working toward the same end. President Wm. A. Hyland, M.D., is to be commended on his unifying efforts, and Chairman N. F. Miller, M.D., on his progressive program. It is to be noted that this Committee has employed a full-time medical secretary, Frank L. Rector, M.D., to effectuate the plans of cancer control in this state.

4. The Commission on Health Care, appointed by the House of Delegates, has been greatly expanded during the past twelve months. Chairman R. H. Pino, M.D., has done a remarkable work in pioneering his well-rounded program of "Medical Associates." The Commission plans a brochure, outlining the opportunities in the field of medical associates to graduates of high schools, junior colleges and colleges of the state. The Council placed at the Commission's disposal a budget of $2,800. A full-time secretary is now employed by the Commission.

5. The Committee on Uniform Fee Schedule for Governmental Agencies, under the Chairmanship of R. L. Novy, M.D., held numerous meetings during the past year in Michigan and with the Veterans Administration in Washington, to effectuate necessary revisions to the Fee Schedule. It is hoped that the new Uniform Fee Schedule for Governmental Agencies will be published and ready for distribution by September, 1947.

6. The High School Athletic Benefit Plan Committee, under the leadership of S. W. Donaldson, M. D., has developed an excellent rapport with the High School Accident Association and the Michigan Department of Public Instruction. This Committee urges increased interest on the part of MSMS members in the High School Accident Benefit Plan which embraces 30,000 prospective patients of Michigan physicians.

7. In May, appointment was made of a new committee with an important task and great potential for good—the Committee to Study the Medical Practice Act.

Contacts with Governmental Agencies

The Michigan State Medical Society continues its important contacts with many governmental agencies, both federal and state. Chief among these during the past year were:

1. *U. S. Congress.*—MSMS was represented at the hearing of the Taft Health Bill (S.545) by Council Chairman E. F. Sladek, M.D., on June 6, 1947.

2. *Contact with individual U. S. Senators and Congressmen in Washington, D. C.*—A meeting of three MSMS representatives with Michigan's congressional delegation on February 14 was a master stroke of good public relations and aided in solving several major misunderstandings and in creating goodwill in behalf of Michigan's doctors of medicine.

3. *The Michigan Legislature.*—The report of the Legislative Committee outlines in detail the numerous bills affecting the practice of medicine which were poised by the Legislature of 1947. After five months in Lansing, the Legislature left behind it a number of laws beneficial to the health of the people of this state. No legislation inimical to public health was adopted. The Legislative Committee, headed by L. A. Drolett, M.D., is to be thanked for its tireless efforts and healthy accomplishment.

4. *The Michigan Crippled Children Commission* and the Michigan State Medical Society continue their fine mutual relationship which has existed for many years, due principally to the co-operative understanding of Chairman Emmet Richards of Alpena, R. V. Walker, M.D., Detroit, the other members of the Commission, and Medical Director Carleton Dean, M.D., of Lansing As a result of amendments to the Afflicted and Crippled Children Acts, made by the 1947 Legislature, a number of revisions in the fee schedule for medical care of Afflicted and Crippled Children are expected.

5. *Michigan Department of Public Instruction.*—The advice of the Michigan State Medical Society was sought by the Michigan Department of Public Instruction on a number of occasions, especially in the matter of training programs under the GI Bill of Rights.

6. *The State Welfare Department* sought MSMS advice in connection with the medical phases of boarding homes for orphans.

7. *University of Michigan.* The annual meeting of the MSMS Liaison Committee with President Alexander G. Ruthven was held in Lansing on June 19. This group, chairmanned by E. I. Carr, M.D., continues to maintain constructive contacts and to foster joint co-operative activities. such as the lectures in medical economics presented by six MSMS officers to the senior and junior classes. The work of the Dean of the Medical School, A. C. Furstenberg, M.D., in efforts to solve the problem of rural medicine and general practice, has been nationally outstanding.

8. *Michigan Department of Health.* Numerous contacts were made during the past year, especially in connection with cancer detection by x-ray, and in discussions concerning practice of medicine by health officers.

9. *Wayne University College of Medicine.* The Medical school also features lectures in medical economics presented by MSMS officers. Dean Hardy A. Kemp, M.D., has been most co-operative particularly in arranging postgraduate continuation courses for MSMS members.

10. *The end of EMIC.* The Emergency Maternal and Infant Care Program, a wartime federal social experiment that snowballed into a taxpayers' nightmare, was liquidated as of July 1, 1947. All women eligible for obstetrical care prior to that date will receive service until April 1, 1948, the final date of this unfortunate experiment. A worth-while result of the EMIC was the attention it spotlighted on the inadequacies, dangers and insidiousness of socialized medicine.

Contacts with Non-Governmental Agencies

1. *Michigan Hospital Service.* The Council is fully aware of the unsolved problem created by the withdrawal of the Mercy hospitals from the Michigan Hospital Service plan, and a committee has been seeking a solution of the problem.

Throughout the year. the actions and deliberations of Blue Cross (Michigan Hospital Service—Michigan Medical Service) have been reviewed and studied by the MSMS Council and its Executive Committee. In cases where clarification and further information were desired, the Boards of these two service corporations were contacted in each case and the medical viewpoint was stressed.

2. *Michigan Medical Service* continues to serve well as a fiscal agent of medical practitioners, as a means of supplying prepaid medical service to the people, and as the leading bulwark among the states against compulsory programs to regiment medicine. Recognition of outstanding service by its President, R. L. Novy, M.D., and its Executive Vice President, J. C. Ketchum, is gratefully recorded.

3. *The Michigan Society for Crippled Children and Disabled Adults* continues to underwrite Michigan's Rheumatic Fever Control Program with a grant to the Michigan State Medical Society of $15,000 annually. Fifteen Rheumatic Fever Centers in Wayne County will soon augment the nine out-state centers which have been in operation for almost two years.

The Alpha Phi Sorority is lending active aid to the Rheumatic Fever Control Program sponsored jointly by the Michigan State Medical Society, the Michigan Society for Crippled Children and Disabled Adults, and the Michigan Crippled Children Commission.

4. *The Child Health Survey,* sponsored by the American Academy of Pediatrics, Michigan Branch, and the Michigan State Medical Society, is nearing completion. Results of this important study, financed and controlled exclusively by voluntary organizations, will be announced in a matter of months.

5. *The State Bar of Michigan* sought the advice of the Michigan State Medical Society's Liaison Committee re the Minnesota Plan to control loose and unethical expert medical testimony.

The State Bar tabled a resolution, on the occasion of its Annual Meeting, which would have favored compulsory health insurance (Wagner-Murray-Dingell Bill).

6. *Michigan Association of Welfare Boards and Boards of Supervisors.* In September, 1946, Secretary L. Fernald Foster, M.D., was invited to address this Association on "The Uniform Fee Schedule for Governmental Agencies." The philosophy behind the Uniform Fee Schedule and the need for its adpotion by county boards of supervisors was thoroughly outlined; the numerous questions of the supervisors were answered.

A recommendation on the Uniform Fee Schedule for Governmental Agencies follows.

7. *Michigan Foundation for Medical and Health Education, Inc.*—This fund, under the Presidency of E. I. Carr, M.D., has made progress during the past year but has not reached its goal of $150,000 in contributions from doctors of medicine. Only after the medical men have proven their interest in their own Foundation—through financial support—can the Trustees of the Foundation seek gifts in larger amounts from lay friends. The Foundation is making plans for active use of income received from its principal.

A recommendation on this subject follows.

Matters Referred to the Council by 1946 MSMS House of Delegates

1. *Appointment of a State Veterans Affairs Committee.*—This Committee was appointed, in accordance with instructions of the House of Delegates; the members of the Committees are composed of veterans, geographically representative of all parts of Michigan.

2. *Humane use of animals for scientific purposes.*—The Council not only followed the instruction of the House of Delegates to "formally protest any interference with the humane use of animals for experimental purposes" but it co-operated in a movement of Michigan scientific men to sponsor a bill to license and regulate vivisection in Michigan; this daring proposal was approved by the Michigan Legislature of 1947, despite bitter activity by antivivisectionists aided by the vigorous promotion of a chain newspaper.

3. *Priorities for doctors of medicine in purchase of automobiles.*—The Council followed through on the instruction of the House of Delegates and held conferences with representatives of the Michigan Automobile Dealers Association in efforts to obtain priorities for Michigan doctors of medicine for the purchase of new automobiles.

New Projects and Miscellaneous Activities

1. *Michigan Postgraduate Clinical Institute.*—The eminently successful experiment was originated at a meeting of the Executive Committee of The Council in October, 1946. The three-day Institute, designed to accentuate throughout the nation the fine postgraduate work and splendid scientific medical men of Michigan, and to strengthen the ties in postgraduate endeavor between the state's medical profession and the MSMS Postgraduate Medical Education Committee, was held in March, 1947, in co-operation with the Wayne County Medical Society, University of Michigan Medical School, Wayne University College of Medicine, the U. of M. Department of Postgraduate Medical Education, and the Michigan Foundation for Medical and Health Education, Inc. The attendance of 1,293 and the publicity of 9,307 lines in Michigan's newspapers attest the high quality program and the masterful job of production, publicity, and public relations accomplished by this experiment. Needless to say, the Institute will be an annual event in Detroit, in the month of March.

2. *General Practice and Rural Medicine.*—This matter was discussed at a number of meetings of The Council and its Executive Committee during the year. The problem of inadequate medical service in rural areas exists and must be solved through the co-operation of the Michigan State Medical Society, the medical schools of the State, and farm organizations interested in the health of their constituents. The Furstenberg Plan, previously mentioned, will interest physicians to practice in smaller communities. However, the production of additional doctors and the permanence of their stay in rural areas are problems not easily solved. Some state medical societies and some state legislatures have developed programs of subsidizing the medical education of youths who agree to spend five years, after internship, in rural areas. Such a program might well be considered in Michigan, for the immediate future.

3. *Remission of dues for young physicians* whose training was interrupted by military service. The Council adopted a ruling in January, 1947, whereby Associate Membership, with remission of dues and assessments, was granted any young physician whose medical training was interrupted by military service.

4. *Sykes grant.*—R. S. Sykes, D.D.S., of Muir, Michigan, presented $500 to the Michigan State Medical Society for use in instruction of doctors "in the difference between non-pathological and true sarcoma or cancer." This gift was accepted by The Council and the grant will be used to provide a lecturer at future MSMS Annual Sessions (September) as well as at the Anuual Michigan Postgraduate Clinical Institute (March) to speak on the subject of "The Differential Diagnosis of Benign and Malignant Tumors."

Recommendations

The Council recommends:

1. That the House of Delegates invite to the attention of county medical societies their opportunity to award honorary memberships on laymen who have contributed outstanding service in behalf of the health of the community; further, that recommendations for awards by the Michigan State Medical Society is the prerogative of the county medical society.

2. That doctors of medicine become more cancer-control minded, and that the House of Delegates use its influence, collectively and individually, to attain this salutary end. If this task is not accomplished by doctors through voluntary means, soon it will be assumed by the goverment, both federal and state.

3. In view of amendments made by the 1947 Michigan Legislature to the Crippled and Afflicted Children Acts whereby the maximum limit on fees for care of these state wards is set at ninety dollars, The Council again

recommends that the House of Delegates urge all component county and district medical societies to make every effort, within the next few months, to negotiate necessary revisions in schedules of benefits covering governmental wards so that individual members of county societies are not penalized by being forced to perform services at a financial loss and below the fees either charged private patients in their particular areas or those indicated in the Uniform Fee Schedule for Governmental Agencies. It is to be noted that the county contractual clause in the Afflicted-Crippled Children Acts limits the Michigan Crippled Children Commission to payment of the county fee, where it is *less* than the MCCC fee schedule.

4. That the Michigan Foundation for Medical and Health Education, Inc., receive enthusiastic personal financial support from doctors of medicine in Michigan, to the end that the Foundation may see larger sums from health-minded laymen—it being the prerogative and responsibility of the medical profession to lead the way in this salutary endeavor.

5. That a Public Relations program be continued, to be financed if necessary by a special assessment.

Respectfully submitted,
E. F. Sladek, M.D., *Chairman*
O. O. Beck, M.D., *Vice Chairman*
L. Fernald Foster, M.D., *Secretary*
C. E. Umphrey, M.D.
P. A. Riley, M.D.
Wilfrid Haughey, M.D.
R. J. Hubbell, M.D.
J. D. Miller, M.D.
R. C. Pochert, M.D.
T. E. DeGurse, M.D.
W. E. Barstow, M.D.
F. H. Drummond, M.D.
R. H. Holmes, M.D.
A. H. Miller, M.D.
W. H. Huron, M.D.
D. W. Myers, M.D.
E. R. Witwer, M.D.
J. S. DeTar, M.D.
W. A. Hyland, M.D.
P. L. Ledwidge, M.D.
A. S. Brunk, M.D

ANNUAL REPORT OF LEGISLATIVE COMMITTEE, 1946-47

The Sixty-fourth Michigan Legislature convened on January 2 and adjourned on June 9, 1947. During this five-month period, 937 bills were introduced; 395 laws were made. Of the bills proposed, 59 dealt directly with or were of primary concern to the practice of medicine.

The 1947 Legislature enacted into law several important measures and amendments sponsored or approved by the Michigan State Medical Society. On the other hand, no proposed legislation that would have lowered Medicine's high standard—and thereby would have been detrimental to the health and welfare of Michigan—was enacted into law in the 1947 session!

Bills Passed by the Legislature

H.F. 451.—This Act will implement in Michigan the provisions of the Federal Hospital Survey and Construction Act. As passed, the law is almost verbatim with the recommendations made by the MSMS Executive Committee of The Council. It calls for a Director to be appointed by the Governor to administer the act with the help of an Advisory Council. No crippling amendments were included in the bill as finally passed in spite of sundry attempts of cultist organizations to use it as an opening wedge for entrance into medical hospitals. The Act specifically provides against any attempt to use the provisions of the law to socialize medicine.

S.B. 201.—As passed this law will license and regulate vivisection. No crippling amendments were made to the bill as originally drafted, despite bitter activity by antivivisectionists aided by the vigorous promotions of a chain newspaper.

S.B. 274,275.—As passed these Acts will raise hospital rates under the Afflicted and Crippled Children's Acts from $7 to $11 and the maximum fee in the Michigan Crippled Children's Commission fee schedule from $75 to $90 (a 20 per cent increase). House Bills 437-438 were identical.

S.B. 378.—This Act would have required immunization against diphtheria, whooping cough and smallpox as a condition precedent to entrance in school. Although passed by the Legislature, the measure was vetoed by Governor Sigler on the basis that it was a step toward regimentation.

Bills Whch Failed to Pass the Legislature

S.B. 215.—This bill would have permitted osteopaths to certify for the commitment of the insane to mental disease hospitals. It was passed by the Senate, but died in a House Committee despite extreme attempts of the osteopaths to force it into law.

H.B. 166 would have provided for licensing of industrial medical assistants, thus dignifying factory first-aiders with professional status.

H.B. 404.—If passed, this proposal would have excepted the chiropractors from the provisions of the Basic Science Law.

H.B. 405.—This bill would have recognized naturopathy as a profession by licensure.

H.B. 416 would have regulated and controlled the sale of pets. This was an antivivisectionists' bill introduced to keep laboratories from obtaining necessary animals for experimental purposes.

H.B. 439 would have limited Blue Cross Plans to participating hospitals only and limited cash awards to the return of one year's premium. It was reported from the Committee on Insurance to the floor of the House, but after a heavy skirmish, was referred back to Committee.

H.B. 495.—If passed, this legislation would have prohibited vivisection and the sale of animals for vivisection purposes.

Other Legislation of Interest to Medical Practitioners

S.B. 1.—Rules and regulations of state agencies, require submission to legislature. Amends administrative code. This law curbs the tendency towards legislation by bureaucratic edict. PASSED and signed by Governor Sigler.

S.B. 4.—This bill, to give Wayne University the status of a State University, is of interest to the medical profession because the medical school of Wayne University is an important component. The bill called for the establishment and regulation of Wayne University as a State school and the fixing of membership and powers of its governing board. H.B. 468 was a similar bill. Died in Senate Committee on Education.

S.B. 10 increases old age assistance on hospitalization to $60. In addition, it removes the requirement that relatives support the applicant if they have financial ability. PASSED.

S.B. 32.—Adoption of minors. Extends probate court jurisdiction as to children of parents to divorce action; releases for adoption, etc. PASSED.

S.B. 50.—Old age assistance: prohibits denial to persons whose income is under $300. PASSED SENATE: Died in House Ways and Means Committee.

S.B. 72 would require approval of the Legislature by concurrent resolution to rescind the license of organizations founded for benevolent or charitable purposes. Might have affected the Michigan Foundation for Medical and Health Education, sponsored by the MSMS. PASSED SENATE: Died in House Committee on State Affairs.

S.B. 75 requires pasteurization of all milk or milk products. This bill was approved by The Council of the Michigan State Medical Society upon recommenda-

tion of the Legislative Committee. H.B. 97 was an identical bill. PASSED.

S.B. 93.—Income tax of 1 per cent on taxable net income. NOT PASSED.

S.B. 94.—Appropriation of $150,000 for state owned American Legion Hospital, Fort Custer. NOT PASSED.

SJR-"H" would have increased membership for state board of education. NOT PASSED.

S.B. 117.—Constitutional convention: provide for submission to electors the question of calling. PASSED.

S.B. 156.—Community property divided between husband and wife each having one-half thereof. PASSED and signed by Governor Sigler.

S.B. 166 permits insurance commissioner to disapprove unfair rates and benefits in health and accident policies. PASSED.

S.B. 249.—Workmen's Compensation Act would amend to require employers to furnish medical and surgical services and medicines for a period of one year after injury. PASSED SENATE: Died in House Committee on Labor.

S.B. 251 would amend Workmen's Compensation Act in regard to physicians' reports and medical records as evidence. NOT PASSED.

S.B. 260 would appropriate $275,000 to construct 50-bed addition to Saginaw County T.B. Hospital. NOT PASSED.

S.B. 261 would impose a net income tax on corporations, limited partnerships. NOT PASSED.

S.B. 271 requires submission to electors of county for establishment of county health department upon filing of petitions of 20 per cent of qualified voters. PASSED.

S.B. 288 would license dental laboratory technologists. NOT PASSED.

S.B. 345 would provide for investigation by Department of Health and control thereof through rules and regulations of occupational disease and industrial health hazards. Died in Committee on Labor.

S.B. 347 would clarify language regarding recovery from estate of responsible relative for care of mentally diseased patients. NOT PASSED.

S.B. 375 would increase ceiling on state refunds to county health departments on cost of operation. PASSED SENATE. Died in House Committee on Ways and Means.

S.B. 376 would repeal sections of criminal code providing for examination for persons accused of murder, for insanity. NOT PASSED.

H.B. 16 *and S.B.* 11.—These identical bills would have provided $1,250,000 for a T.B. Sanitarium in Kalamazoo. NOT PASSED.

H.B. 115 would require physical examination of participants in boxing or wrestling at least once each four months; limits participation to not oftener than one each week. PASSED HOUSE: Died in Senate Committee on State Affairs.

H.B. 122 would require the state to stand full financial support of all public patients, i.e., insane, feeble minded, epileptic or mentally diseased persons. NOT PASSED.

H.B. 163.—Silicosis would be placed on same basis as other occupational disease under Workmen's Compensation Act. NOT PASSED.

H.B. 204 extends liability for care of insane persons in state hospitals to include patient. PASSED.

H.B. 207 repeals war termination clause of act designating superintendent of public instruction as agent to receive any federal grants to state in aid of education. PASSED.

H.B. 211 would change school code to include all ages for classes for physically handicapped. NOT PASSED.

H.B. 235 would amend Workmen's Compensation Act in regard to appointment of liability on occupational diseases. NOT PASSED.

H.B. 281 would increase the county clerk filing fee from 50 cents to $1.00 for certificates of registration of physicians and surgeons. PASSED.

H.B. 323 would amend Workmen's Compensation Act to allow commission to fix amount of bill and order such appliances as dental service, artificial limbs, etc. PASSED HOUSE: Died in Senate Committee on Labor.

H.B. 378 would require completion of 8 grades of school or certificates from a physician or psychologist showing that such person is not feebleminded. NOT PASSED.

H.B. 409 provides for secrecy of birth and death records of illegitimate children. PASSED.

H.B. 421 permits temporary detention by police officer for not to exceed 48 hours not counting Sundays and holidays. PASSED.

H.B. 427 would create new state department to take over duties of department of mental health and other departments. NOT PASSED.

H.B. 475 authorized Department of Mental Health to lease property of Munson Hospital to a nonprofit corporation to operate a general hospital in Traverse City. This proposal was favored by the medical profession of Grand Traverse County. PASSED.

H.B. 487 would amend Workmen's Compensation Act to permit employes' choice of medical, surgical and hospital services. NOT PASSED.

H.B. 486 would amend Workmen's Compensation Act to require employers to furnish to any employe any medical information they have regarded such employe. Died in House Committee on Labor.

H.B. 500 would have made general amendments to the Hospital Act for mentally diseased persons. Died in House Committee on Judiciary.

H.B. 542.—Tuberculosis: would increase state aid to sanatoriums for free patients from $2.50 to $3.00 per day. Removes ceiling. NOT PASSED.

Thanks

The Legislative Committee again expresses appreciation to the intelligent and health minded members of the Michigan Legislature for their courteous consideration of the legislative problems of the medical profession and the fair minded reception they extended our representatives during the 1947 session.

To Governor Kim Sigler, the Legislative Committee is grateful for friendly co-operation that he and his associates in the Executive Office extended to the medical profession in all health matters.

The Committee also wishes to express its sincere thanks to the members of the medical profession throughout the state who kept their friends in the Senate and the House well informed concerning medical legislation.

Our many thanks to William J. Burns and Hugh W. Brenneman who worked so hard to keep us informed and lay the ground work for the Committee's efforts during the year.

Respectfully submitted,

L. A. Drolett, M.D., *Chairman*
William Bromme, M.D.
E. F. Ducey, M.D.
H. B. Fenech, M.D.
D. L. Finch, M.D.
Nicola Gigante, M.D.
C. S. Gorsline, M.D.
T. K. Gruber, M.D.
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E. W. Schnoor, M.D.
E. F. Sladek, M.D.
J. G. Slevin, M.D.
E. S. Thornton, M.D.
R. V. Walker, M.D.
George Waters, M.D.
A. V. Wenger, M.D.
J. B. Whinery, Jr., M.D.

ANNUAL REPORT OF PUBLIC RELATIONS COMMITTEE, 1946-47

The Public Relations Committee was expanded this year so that a representative from each of the MSMS Councilor Districts was placed on the Committee. Six permanent subcommittees and several temporary advisory committees are working actively on special projects.

The program of MSMS Public Relations has become organized, well ordered and enthusiastic. It is impossible to record here the multitudinous contacts with lay organizations, communication media and personnel, medical organizations, important individuals in the business and professional world, legislators, health and educational organizations, practicing physicians, etc. Yet these contacts have been of utmost importance in making possible the highly successful PR effort of your State Society. Nor is it possible to enumerate the many instances in which action has been taken to guard the profession from attack, misrepresentations, etc.

The Public Relations Committee has met in full on four occasions and in subcommittees on seven occasions. The work of these committees is included in this report. Their membership is as follows:

Committee on Development of Literature: Wilfrid Haughey, M.D., Chairman; W. D. Barrett, M.D.; D. R. Brasie, M.D.; C. W. Colwell, M.D.; W. B. Harm, M.D.; H. J. Kullman, M.D.; A. E. Schiller, M.D. *Committee on Distribution of Literature:* C. L. Weston, M.D., Chairman. *Special Committee on Radio:* C. L. Candler, M.D., Chairman; A. S. Brunk, M.D.; P. L. Ledwidge, M.D. *Committee on Cinema:* F. R. Reed, M.D., Chairman; L. Fernald Foster, M.D.; Wm. J. Burns. *Committee on Awards:* L. Fernald Foster, M.D.; Wilfrid Haughey, M.D.; J. Milton Robb. *Scientific Radio Committee:* H. M. Pollard, M.D., Chairman; J. H. McMillin, M.D.; R. W. Meredith, M.D.; F. R. Reed, M.D.; G. M. Waldie, M.D.; F. A. Weiser, M.D.; L. J. Morand, M.D.; J. S. DeTar, M.D.; H. A. Kemp, M.D.; R. M. McKean, M.D. *Committee on Radio and Newspaper Review:* C. A. Payne, M.D; G. T. Aitken, M.D. *Committee on Dramatized Radio:* R. W. Teed, M.D., Chairman. *Committee on Newspaper Policy:* L. E. Holly, M.D.; H. J. Meier, M.D.

In all meetings the main thought has been to plan activity in advance which, culminating in six months, a year, two or three years, will keep the medical profession in a position of leadership in the entire health field in the eyes of the public. Such leadership is inexpensive compared to the complications which ensue if medicine takes a secondary role; yet funds must be available and at the present time are at hand due to the $25 per capita assesment. These funds are expended only after an elaborate and effective series of qualifications have been met. Below is a skeleton report of some of the activity sponsored by the Public Relations Committee during 1947.

Newspapers

News Releases.—Releases have been made on each MSMS member appointed to a MSMS Committee. Releases on activity of MSMS meetings have received excellent usage. Example: 9,307 lines of newspaper space were given to the Michigan Postgraduate Clinical Institute including editorials and pictures. Releases have been issued on all matters of news interest developed within the Society on the state level. Articles have been publishd in the *Michigan Farmer* magazine and in medical journals.

Health News Column.—A weekly column is distributed in mat form to 157 weekly newspapers in the state. This column provides the public with authoritative information on health and medical developments as well as on socio-economic problems affecting health.

Advertising.—By the use of all daily papers and selected weekly newspapers the coverage of the ads has reached a minimum of 80 per cent of the people in every area of the state. In addition the ads have been run in labor newspapers and in the *Michigan Farmer* magazine. Ads used were six 4 x 7½ (dailies) and 4 x 6 (weeklies) for a total of eighteen advertisements in each paper scheduled for the year; twenty-one in the Detroit area. These advertisements are of the institutional variety using the idea that medical organization is solving the need for a constructive program of health care in Michigan, with the end in mind of obtaining increased public support for the system of private practice of medicine.

Radio

"Tell Me, Doctor"—This daily health news broadcast prepared on transcriptions is being heard regularly over fifteen stations in Michigan. It is prepared and distributed under the direction of the PR Counsel and a subcommittee of the Public Relations Committee.

"Medical Talks".—A University of Michigan-Michigan State Medical Society weekly fifteen-minute scientific program heard over three stations in Michigan—WJR, Detroit; WKAR, East Lansing, and WMIQ, Iron Mountain.

"Doctor of Medicine".—A weekly ten-minute program over CKLW, Detroit, featuring a guest doctor of medicine speaking on a subject of medical interest.

Co-operative Radio.—Various organizations and some county medical societies have sponsored radio programs. The Michigan State Medical Society has in many cases either provided scripts or personnel in co-operation with both lay and medical groups.

(Total number of sixty-minute radio hours.....372)
(Total number of radio programs per annum..3,861)

Cinema

Catalogue.—Work is going forward to develop a catalogue of available films on health subjects.

Projector.—An illustrovox has been obtained and is available for the showing of strip films or slide films or for the playing of transcriptions.

Pamphlets

To Members.—P. R. Supplement No. 1 (covering the newspaper publicity and advertising activity) and P. R. Plan Supplement No. 2 (treating the subject of MSMS Radio programs) to the Public Relations Plan have been prepared and will be distributed shortly.

A Public Relations Bulletin is being issued monthly. This was temporarily suspended during the Legislative Session when many legislative bulletins were issued.

To Schools.—Every available pamphlet has been obtained on the subject of compulsory sickness insurance and voluntary health insurance, put into kits, and mailed to every high school in the state.

A pamphlet "Check and Double Check" has been ordered in quantity so that one may be sent to each member. Only 400 have been received from the printer and these have been issued.

New Pamphlets.—Three pamphlets are being published, one for schools, one for civic groups, and one for lay distribution.

Pamphlets for Related Organizations.—One pamphlet for the Michigan Society for Crippled Children and Disabled Adults is being prepared on the MSMS Rheumatic Fever Control program. Two pamphlets on the Michigan Foundation for Medical and Health Education, Inc., have been prepared and are being issued.

Display

A card for display in doctors' offices promoting the "Tell Me, Doctor" has been prepared and distributed. No other display has been prepared pending the obtaining of display fixtures.

IDWTGTRMB Club

The IDWTGTRMB Club has been set up as a separate nonprofit corporation and continues to gain membership and publicity in opposition to efforts of those who espouse the tenets of socialism.

Organizational

Michigan Rural Health Conference.—With twenty-five other state organizations as cosponsors, this Conference will be held at East Lansing on the campus of Michigan State College on September 18-19.

Schools

A sex education program for use in schools is being prepared in co-operation with Wayne University. A trial was made of a sample program in Benton Harbor before a Parent-Teachers Association and the results indicate enthusiastic acceptance. For distribution of pamphlets to schools see "Pamphlets."

Annual Reports

Medical Plan for Michigan.—The outline for this compilation of activities of the MSMS and related organizations which in effect constitutes a Medical Plan for Michigan has been prepared and currently is being written for publication and distribution in September.

Public Platform

Speakers Bureaus.—A speakers bureau has been set up in the majority of county medical societies. Representatives of the Michigan State Medical Society have appeared before many lay groups.

Speakers Kits.—These have been prepared and sent to all members of county speakers bureaus.

Awards

A system of awarding recognition to outstanding lay people and organizations performing outstanding service in the cause of health has been set up. Three persons and one organization have been cited: Charles F. Kettering, Detroit; Emmet Richards, Alpena; Percy Angove, Detroit; Michigan Society for Crippled Children and Disabled Adults.

Co-operation With State and National Medical Societies

Upon request the MSMS has offered concrete and direct advice both personally and by letter to fifteen state medical societies. A national meeting of State Public Relations Counsels was held informally in Chicago on February 8 at the urging of MSMS. A system of exchange of public relations materials has been adopted and is now in use. Attendance, participation, and co-operation in programs of the AMA have been carried out to the fullest extent. Excellent relations have been esablished in the public relations efforts of the National Physicians Committee and other national organizations fighting the cause of private practice.

Michigan Rural Survey

A survey of needs for medical care in Michigan and the availability of medical care as well as the extent of other health services and public reaction is being planned in connection with the Social Research Bureau of Michigan State College.

* * * * * * *

Hugh W. Brenneman as Public Relations Counsel has forwarded and implemented the desires of the Committee. His counsel has served to correlate the public relations activities of the various committees of the MSMS with the Public Relations Committee toward the end that general stimulation has been gained and constructive activity planned.

Wallace-Lindeman, Inc., of Grand Rapids, was retained as advertising counsel in November to aid in implementing portions of the Public Relations Plan. The work of this Agency has been consistently of high caliber, its advice valuable. This organization has assisted in the newspaper, radio, pamphlet and display campaigns and in many instances it has been able to save the Society's funds by obtaining favorable quotations from printers, writers, technical men, etc.

The $25 individual assessment voted by the 1946 House of Delegates for the 1947 program of public relations has been budgeted as follows:

Newspapers	$8.25
Radio	3.53
Michigan Rural Health Survey	1.18
Michigan Rural Health Conference	.45
Medical Education	2.35
Medical Plan for Michigan	1.65
Purchase of Pamphlets	.70
PR and Secretaries Conference	.52
Michigan Health Council	1.18
School	.23
Display	.23
Cinema	.23
Child Health Survey	.23
Conference of Presidents	.05
Committee Meetings	.23
National Conference on Medical Service	.10
Travel Expense	.45
New Equipment	.17
Postage	.21
Printing, Stationery and Supplies	.10
Telephone and Telegraph	.19
Rent	.10
Salaries	2.60
Miscellaneous	.07

The Public Relations Committee urges the continuation of a Public Relations program in 1948.

Respectfully submitted,

J. S. DeTar, *Chairman*
C. L. Candler, M.D., *Vice Chairman*
A. S. Brunk, M.D.
C. R. Keyport, M.D.
C. L. Weston, M.D.,
N. J. Frenn, M.D.
L. T. Henderson, M.D.
W. J. Herrington, M.D.
S. W. Insley, M.D.
L. E. Holly, M.D.
P. L. Ledwidge, M.D.
J. J. McCann, M.D.
G. B. Saltonstall, M.D.
G. A. Zindler, M.D.
D. K. Barstow, M.D.
Arch Walls, M.D.
C. A. Payne, M.D.
G. T. Aitken, M.D.
Wm. S. Jones, M.D.
R. W. Teed, M.D.
K. H. Johnson, M.D.
R. J. Meier, M.D.
A. F. Bliesmer, M.D.
E. A. Oakes, M.D.
J. E. Livesay, M.D.
E. S. Parmenter, M.D.
H. M. Pollard, M.D.
F. R. Reed, M.D.
F. J. O'Donnell, M.D.

ANNUAL REPORT OF COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION, 1946-47

The Committee on Postgraduate Medical Education held its usual two meetings during the year 1946-47, the first on January 18, 1947, and the second on June 19, 1947. About one-half of the committee members attended these meetings, but those attending showed a keen interest in the work and offered valuable constructive criticism.

The Committee changed the type of program for the year, using a panel discussion made up of four speakers in various fields of medicine. The doctors in the teaching centers were asked to appoint a physician as moderator from their vicinity who specialized in the field under discussion. After the reports of the Spring meetings of 1947 were studied, it was the decision of the Committee that a member of the panel be selected as moderator, this plan to be tried out during the meetings of October and November, 1947.

The Committee is happy to report that the teaching center of Sault Ste. Marie was used on May 26, 1947, and that twenty-six doctors attended, which is 104 per cent for that district. In other words, more doctors than those practicing in that territory attended. The teaching at Powers was not given this Spring because that date fell upon Memorial Day and our councilor in that region advised against holding the meeting. The subjects which were selected by the Committee and given in the different teaching centers were as follows:

Autumn, 1946

1. The Prognostic Significance of the Signs and Symptoms of Heart Disease.
2. The Differential Diagnosis of Chronic Pulmonary Disease.
3. Convulsions in Infancy and Childhood. Differential Diagnosis and Management.
4. Anemias in Infancy and Childhood.
5. Diagnosis and Treatment of Disease of the Peripheral Vascular System.
   (a) Acute Thrombosis.
   (b) Peripheral Vascular Deficiency.
   (c) Varicose Veins.
6. Indications for Caesarean Section.

Spring, 1947

Panel Discussion: Management of Pediatric Emergencies.
Panel Discussion: Clinical Manifestations of Allergy.

In spite of blizzards, impassable roads, and floods causing cancellation of the original dates of meetings in three centers, the same program was presented later. These cancellations undoubtedly explain the lessened attendance at the substitute meetings. However, in spite of these things, 1,218 physicians attended one or more of the four meetings given in all of the teaching centers of the state. This is an increase of thirty-three doctors attending the meetings.

During both meetings of the Committee on Postgraduate Medical Education, a matter of a change in the type of program was discussed. It was felt that using the panel type of presentation for one year might stimulate greater interest in the whole program. This experiment will be continued during October and November of this year. The Committee has in mind other types of programs and will undoubtedly recommend these for experimental tests. It is felt by the Chairman and the Committee that the doctors tire of one type of program and that from time to time changes should be made. At present, the Committee feels that each session should deal with one subject only, and that more opportunity should be given for questioning by attending physicians. The attendance record on the Extramural Centers was as follows:

Ann Arbor	93
Battle Creek-Kalamazoo	186
Bay City-Saginaw	147
Flint	140
Grand Rapids	156
Jackson	102
Lansing	127
Mt. Clemens	73
Traverse City	90
Upper Peninsula: Marquette-Houghton-Ironwood-Sault Ste. Marie	104
Total Physicians	1,218

Teachers were obtained from both medical schools, and by the selection of physicians throughout the state. The numbers are as follows:

Wayne University College of Medicine	10
University of Michigan Medical School	25
Teachers Affiliated with the Department of Postgraduate Medicine as Postgraduate Lecturers	11
Total Lecturers	46

The new type of postgraduate conference held in Detroit on March 12, 13, and 14, using only state talent as essayists, was heartily received and approved of by most of the doctors of the state. The numbers attending the three-day meetings were:

Detroit Portgraduate Clinical Conference	
March 12, 1947	703
March 13, 1947	285
March 14, 1947	94
Total:	1,255

The reception of this type of meeting leads the Committee to recommend its repetition annually. It is felt that many well-trained physicians in the state should be used as speakers for this program and that it is especially stimulating to the younger, able, and talented doctors of medicine in our midst, and who should be used at subsequent conferences of this kind.

The Michigan State Medical Society granted 30 Certificates of Fellowship, and 21 Certificates of Associate Fellowship in Postgraduate Education in September, 1946.

Intramural Activities

Herein is appended a record of Postgraduate Continuation Program for the year 1946-47, given in Wayne University College of Medicine. This shows a rapidly developing and well attended curriculum of postgraduate teaching. The large number of physicians returning from military duty taking the work in this center speaks well for the program and the continuing interest of these returning medical veterans.

At the University of Michigan Medical School, the attendance fell from 1,010 in 1945-46 to 993 in 1946-47. The explanation is that the very heavily attended course lasting two months dealing with Application of the Basic Sciences failed to attract physicians coming out of military service as it had the year before. Undoubtedly, these men are settled in practice and devoting their entire time to it.

The various courses offered with the exception of basic sciences course had about the same attendance as in the previous year. Some of them had increased in registration. The registration in each course is given below:

Clinical Internal Medicine	54
Application of the Basic Sciences	36
Decentralized Resident Training Program	29
Clinical Exercises for Practitioners	29
Electrocardiographic Diagnosis	77
Anatomy	68
Diagnostic Roentgenology	38
Otolaryngology	45
Ophthalmology	100
Pediatrics	16
Diseases of the Heart	34
Diseases of the Gastroeintestinal Tract	17
Recent Advances in Therapeutics	32
Diseases of the Blood	12
Allergy	20
Metabolism and Endocrinology	20
American College of Physicians	
Cardiology	40
Internal Medicine	51
Personal Courses (Interns, Assistant Residents, Residents, and miscellaneous registrations)	218
Foreign Doctors	57
Total:	993

A total of 478 veterans attended the Intramural Courses for the year 1946-47.

The Committee wishes to thank the teachers who prepared and gave the lectures in both the Intramural and Extramural work. It feels that there are capable young teachers who has not been used in the Michigan Plan of Postgraduate Medical Education, and it desires to be informed about this group so that it may call on it to relieve some of the older physicians who have carried the teaching load for many years. It is still the opinion of the Committee that Postgraduate Medical Education as carried on by the Michigan State Medical Society, Wayne University College of Medicine, University of Michigan Medical School, and also the State Department of Health is the most useful of State Society activities and that it is continuing to serve a most useful purpose in aiding the physicians of the state in being informed of the progress in medicine, and of passing on to their

patients better medical services. The Committee is indeed grateful for the interest and active support of all of the members of the Michigan State Medical Society.

Respectfully submitted,

H. H. Cummings, M.D., *Chairman*
E. I. Carr, M.D., *Vice Chairman*
C. F. Brunk, M.D.
B. R. Corbus, M.D.
G. J. Curry, M.D.
C. P. Drury, M.D.
W. B. Fillinger, M.D.
A. C. Furstenberg, M.D.
C. B. Gardner, M.D.
C. L. Hess, M.D.
R. H. Holmes, M.D.
H. A. Kemp, M.D.
R. S. Morrish, M.D.
R. H. Pino, M.D.
H. M. Pollard, M.D.
P. A. Riley, M.D.
J. M. Robb, M.D.
W. R. Torgerson, M.D.
J. J. Walch, M.D.

ANNUAL REPORT OF COMMITTEE ON RURAL HEALTH, 1946-47

The Committee on Rural Health held three meetings during the past year, on September 23, 1946, and on April 9 and June 2, 1947. Other informal meetings were held by members of the committee with various representatives of health and lay organizations interested in better distribution of medical care in rural areas.

In our Committee efforts to solve the need for medical care which exists in Michigan in certain rural areas, the Committee's activities centered primarily on discussion of the following five items:

1. *Michigan Rural Health Conference.*—The first annual Michigan Rural Health Conference is scheduled for September 18-19 at Michigan State College, East Lansing. It will gather together all farm groups, county agents, local health officers, supervisors, farm security administration representatives, health groups, representatives of eleemosynary institutions, and other organizations interested in rural health. The Conference will be sponsored by the Michigan State Medical Society, in co-operation with twenty-seven other health and lay organizations. Its publicity and public relations should do much to increase interest in rural medical practice and to impress upon the public the major part in this activity being taken by the medical profession of Michigan.

2. *Michigan Rural Health Survey.*—The Committee studied the possibility of a survey of medical needs in rural areas under a plan prepared by the Michigan State College Social Research Service. Such a survey would complement the Michigan Hospital Survey and would serve three purposes: obtain an accurate account of the need for medical care in rural and small town areas; obtain the amount of care being given by healers other than doctors of medicine; service as an educational project for acquainting a large segment of the population with their individual needs for medical care and the various means to obtain it.

The survey would require some three years and cost approximately $15,000 per year. Your Committee on Rural Health approved the project, and recommended co-operation by the Michigan State Medical Society. It is gratifying to know that The Council indorsed this recommendation.

3. *Federal Hospital Survey and Construction Act and Its Michigan implementation under House Bill 451 of 1947.*—This legislation definitely will aid rural communities with a $2,000,000 per annum grant from the federal government matched by $4,000,000 per year from local units, a hospital building program in rural communities of $6,000,000 per annum. Hospitals will be built to attract physicians to areas where medical care is inadequate so that the doctor of medicine can practice where modern medical facilities are present. A definite need for family practitioner of medicine service is needed now, since they are not being provided in adequate amounts, and as the result, substandard care by healers other than doctors of medicine is replacing the family physician in rural areas. The implementation of the Federal Hospital Construction Act (Michigan's H.B. 451) was passed by the 1947 Legislature. It will definitely aid this committee in its work of interesting more doctors of medicine to practice in rural areas by giving them an adequate workshop.

4. *Survey of X-ray and Laboratory Needs.*—The Committee recommended to The Council that a survey of x-ray and laboratory needs be made with the objective of finding some solution in supplying these needs to better rural medical service. The work of the Kellogg Foundation in establishing x-ray and pathology equipment in rural communities was investigated thoroughly by the Committee.

5. *Lectures on Rural Medical Practice to Senior Medical Students.*—Your Committee recommended that a rural practitioner of medicine present one of the six lectures on medical economics, stressing the advantages of rural practice, to the senior medical students at the two Michigan medical schools. This recommendation has been adopted.

Other activities aimed to better distribute medical care in rural areas: (a) The Committee recommended to Michigan Hospital Service-Michigan Medical Service that they make a concerted effort to increase enrollment in rural and small-time communities at the earliest possible moment. In addition, this Committee recommended to MHS (through the MSMS Council) the inclusion of hospital service for obstetrical cases in its direct-pay plan contracts, and that if necessary, it limit such service to $50.

(b) The Committee discussed scholarships for prospective doctors who would practice in rural areas, which subject is still under consideration.

The idea of preceptorships to be carried out in Michigan under the Wisconsin Plan was recommended as a possibility for increasing interest in rural medical practice.

Respectfully submitted,

H. B. Zemmer, M.D., *Chairman*
R. J. Hubbell, M.D.
W. H. Huron, M.D.
John Rodger, M.D.
E. R. Witwer, M.D.

ANNUAL REPORT OF COMMITTEE ON INDUSTRIAL HEALTH, 1946-47

The Committee on Industrial Health held no formal meetings during the year. Unsuccessful attempts were made to continue the jointly sponsored in-plant meetings inaugurated last year. These meetings were sponsored by the Committee on Industrial Health, the local medical society and a large manufacturer which served as host.

In spite of the fact that no meetings were held, the Medical Society, through its industrial health committee, was alert to new developments in the field, particularly with respect to health and welfare programs.

In August, the chairman of the committee accompanied Jay C. Ketchum, Executive Vice President of Michigan Medical Service, to Williamson, West Virginia, to attend a meeting called by the "Association of Mine Physicians" to discuss the health and welfare proposals of the "National Bituminous Wage Agreement." The

chairman also attended the seventh annual meeting of the Council on Industrial Health of the American Medical Association in Boston, September 30-October 2. Rear Admiral Joel T. Boone, U.S.N.; Mr. Boris Stern, U. S. Department of Labor; and Mr. Andrew Fletcher, Vice President of the St. Joseph Lead Company, discussed the various aspects of health and welfare clauses.

The regional in-plant meetings mentioned above are an excellent means of bringing the industrial physician and the private practitioner together to discuss mutual problems and actually to inspect the working environment of the industrial worker. These meetings are worthy of repetition.

Respectfully submitted,

K. E. Markuson, M.D., *Chairman*
H. H. Gay, M.D., *Vice Chairman*
A. L. Brooks, M.D.
W. P. Chester, M.D.
Henry Cook, M.D.
W. A. Dawson, M.D.
W. B. Harm, M.D.
J. E. Livesay, M.D.
V. S. Laurin, M.D.
J. D. Miller, M.D.
C. D. Selby, M.D.
H. T. Sethney, M.D.
L. E. Sevey, M.D.
M. W. Shellman, M.D.
E. C. Sites, M.D.
F. B. Williamson, M.D.

ANNUAL REPORT ON SCIENTIFIC RADIO COMMITTEE, 1946-47

During 1947, fifteen-minute radio broadcasts have continued at weekly intervals over WJR, Detroit. They have been rebroadcast over WKAR, East Lansing, and WMIQ, Iron Mountain. As in the past these programs originated at the campus of the University of Michigan with the exception of a few talks which were given from the main studios of WJR in Detroit.

It is now possible to transcribe the talks prior to the time of broadcast, thereby making it more convenient for the individuals presenting the talks.

The subject matter has been varied, an effort being made to include several talks in each field of medicine. Four speeches were presented by members of the Cancer Control Committee of the Michigan State Medical Society. Suggestions were made by the MSMS Preventive Medicine Committee regarding suitable subjects.

It is hoped that next year this radio series can include a wider representation of the Michigan State Medical Society in presenting subjects of their interest.

Respectfully submitted,

H. M. Pollard, M.D., *Chairman*
J. H. McMillin, M.D.
R. W. Meredith, M.D.
F. R. Reed, M.D.
G. M. Waldie, M.D.
F. A. Weiser, M.D.
L. J. Morand, M.D.
H. A. Kemp, M.D.
R. M. McKean, M.D.
J. S. DeTar, M.D.

ANNUAL REPORT OF COMMITTEE ON MEDICAL ECONOMICS, 1946-47

In January, 1946, an arrangement was made with the Medical Schools of Wayne University and the University of Michigan whereby a series of lectures could be given to medical students on Medical Economics, and to explain also the aims and purpose of membership in a medical society.

The first lectures, two in number, were given before the Seniors of Wayne University, but the college year was nearing its close, and no more could be given at that time. Later in the year four lectures were given to the Senior class at the University of Michigan, and repeated later for the Juniors. The response to these talks was so encouraging that it is the opinion of your Committee they should be enlarged upon, and given in greater number. The co-operation of the Deans of the two schools has been excellent and helpful, and they have arranged to meet with this committee sometime after the fall semester begins, to plan for more lectures.

This is organized medicine's opportunity to tell its aims and objectives to the developing doctor while he is still in the formative stage, and it is the opinion of this Committee that such opportunity should be taken advantage of to its fullest measure, and continued as a part of future training to all medical students.

Those who gave of their time to present these lectures were:

Wilfrid Haughey, M.D.	J. S. DeTar, M.D.
John Rodgers, M.D.	L. F. Foster, M.D.
Jackson Livesay, M.D.	R. S. Morrish, M.D.

Respectfully submitted,

R. S. Morrish, M.D., *Chairman*
Wilfrid Haughey, M.D.
L. F. Foster, M.D.

ANNUAL REPORT OF SPECIAL COMMITTEE ON RADIO, 1946-47

The Special Committee on Radio had several meetings early in the year. The last several months its only job has been reading and censoring the material on Hack's Shoe Store program over Radio Station CKLW. This program has been a variety of medical subjects written by Detroit's doctors of medicine. As far as we know, this program has been favorably received as we have received no complaints.

Respectfully submitted,

Clarence L. Candler, M.D., *Chairman*
A. S. Brunk, M.D.
P. L. Ledwidge, M.D.

ANNUAL REPORT OF COMMITTEE ON POSTWAR EDUCATION, 1946-47

Your sub-committee on Postwar Education has had no occasion to function during this past year.

The work of this committee was taken over a long time ago by the Committee on Postgraduate Medical Education, and I advise, as I advised last year, that this committee be discontinued.

Respectfully submitted,

B. R. Corbus, M.D., *Chairman*
G. J. Curry, M.D.
J. M. Robb, M.D.
W. H. Marshall, M.D.
O. W. Lohr, M.D.
L. V. Ragsdale, M.D.
H. H. Cummings, M.D.

ANNUAL REPORT OF MSMS DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION, 1947

The Annual Report of the Delegates to the American Medical Association will be presented verbally at the first meeting of the MSMS House of Delegates.

Michigan's Department of Health

Wm. De Kleine, M.D., Commissioner, Lansing, Michigan

VACATION CASUALTIES

Those who will vacation in Michigan were warned in June to anticipate 1,000,000 vacation casualties in the state this summer. Newspapers and radio co-operated with the department in calling attention to the major hazards of overexposure to the sun, overexertion, swimming, boating, poison ivy and the possibility of contaminated milk, water and food supplies.

SMALLPOX APPEARS IN STATE

Michigan's first case of smallpox in seven months was reported from Lenawee county early in June. It was a hardware dealer who lives in Hudson near the Hillsdale county line. How he contracted the disease was not immediately learned. The department issued its third warning that the residents of this state are not sufficiently immunized against the disease.

COUNTING POLLEN GRAINS

The Department's seventh annual pollen survey to advise Michigan summer residents of the concentration of ragweed pollen got under way in 48 collecting stations in the state July 1. The period having the greatest concentration of ragweed pollen is from August 15 until the first killing frost. Approximately 1,000 reports on individual collecting stations are made to various newspapers and radio stations each day.

RAPID TREATMENT CENTER THREE YEARS OLD

More than 7,800 patients have been treated for venereal disease in the Michigan Rapid Treatment Center, Ann Arbor, in the three years since it was established. Only two per cent of the patients have been readmissions. About 58 per cent of those treated are men and 55 per cent of those treated are under twenty-five years of age. The Center had been open three years, July 5.

TOURIST RESORTS INSPECTED

Ten sanitary engineers have been added to the staff of the Department for the summer to conduct the resort sanitation program for the protection of vacationists and tourists. They will work primarily in counties where there are no health departments. Other engineers from the department as well as from city, county and district health departments are co-operating in the work which is conducted annually. Resorts, hotels, children's camps, tourist and trailer camps and other recreational centers which bid for tourist trade will be inspected. Water supplies, sewage disposal methods, food and milk supplies and handling, swimming places and other resort facilities will be checked. "Safe For Drinking" signs will be posted where water is safe and "Sanitation Approved" signs will be posted where it is safe to stop to eat or rest.

TUBERCULOSIS NEAR AVERAGE

Tuberculosis took the lives of nearly twice as many men as women in Michigan in 1946. Male deaths due to tuberculosis were 1,214, and female deaths, 629. Forty-five per cent of female tuberculosis deaths occurred among women under thirty years of age, while 49 per cent of male tuberculosis deaths occurred in men above sixty years of age.

Of the total of 1,843 deaths attributed to tuberculosis, sixty-four were of children under five years of age and twenty were of children under one year. The death rate from tuberculosis is 33.4 per hundred thousand population and is near the five-year average of 32.6 per hundred thousand population. Tuberculosis is the seventh cause of death among men and the eighth cause of death among women in this state.

SWIMMERS ITCH PROGRAM CONTINUED

To protect vacationists at Michigan's lakes from swimmers' itch, the snail eradication program of the Michigan Stream Control Commission got under way in June for its eighth consecutive year. The Commission furnishes men and chemical distributing equipment to treat shorelines where property owners or communities request the service and furnish the chemicals.

RABIES VACCINATION

Governor Sigler has signed a bill which permits the board of supervisors in counties quarrantined for rabies to require vaccination of a dog for rabies within a year before the dog is issued license.

HEALTH DEPARTMENT LAW PASSED

The nine per cent of Michigan's population which does not have the services of a local health department may now take the initiative in getting them. Under new legislation, a petition signed by five per cent of the electors of the county can require the board of supervisors to place the question of establishing a health unit on the ballot at the next general election. A favorable majority vote can require the establishment of the department. Only 12 counties in the state do not have local services.

VIVISECTION LAW PASSED

Governor Sigler signed into law a bill which insures humane use of animals for experimental purposes and production of biologics under rules laid down by the State Health Commissioner with the approval of an advisory council appointed by the Governor. The bill also requires that all animals kept or used for experimental purposes be registered with the State Health Commissioner.

Benzedrine Inhaler, N. N. R.
". . . is quite effective in the clearing of nasal congestion due to allergy or infection."

Feinberg. S. M.: Allergy in Practice, Chicago, The Year Book Publishers, Inc., 1944, p. 502.

Your hay fever patients will be grateful . . . particularly between office visits . . . for the relief of nasal congestion afforded by Benzedrine Inhaler, N. N. R. The Inhaler may make all the difference between weeks of acute misery and weeks of comparative comfort.

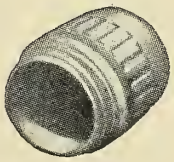
Benzedrine Inhaler

ACCEPTED COUNCIL ON PHARMACY AND CHEMISTRY AMERICAN MEDICAL ASSOCIATION

Each Benzedrine Inhaler is packed with racemic amphetamine, S.K.F., 250 mg.; menthol, 12.5 mg.; and aromatics.

a better means of nasal medication

Smith, Kline & French Laboratories
Philadelphia, Pa.



What's What

Carl C. Birkelo, M.D., Detroit is co-author of an original article "Tuberculosis Case Finding" which appeared in JAMA of February 8, 1947.

* * *

O. D. Stryker, M.D., Fremont, MSMS Councilor, has been appointed the first health officer of Macomb County.

* * *

Henry J. Vanden Berg, M.D., F.A.C.S., of Grand Rapids, is the author of a paper, "Diagnosis and Therapeusis of Simple Cysts of the Breast," published in *Surgery, Gynecology and Obstetrics,* August, 1946, pages 239-242.

* * *

The Mississippi Valley Medical Editors' Association will hold its fourth meeting at Hotel Burlington, Burlington, Iowa, on October 1, during the meeting of the Mississippi Valley Medical Society in that city. For copies of detailed program write Secretary Harold Swanberg, M.D., 209 W.C.U. Bldg., Quincy, Ill.

* * *

The American College of Allergists announces its autumn graduate instructional course in allergy, scheduled for Cincinnati, Ohio, November 3-8 at the Musical College of the University of Cincinnati. For complete information write Secretary Fred W. Wittich, M.D., 423 LaSalle Medical Building, Minneapolis 2, Minnesota.

* * *

Detroit's newest hospital, Holy Cross Hospital, 4777 E. Outer Dr., Detroit, elected the following staff officers for the year beginning June 1, 1947: Chief of Staff, Henry J. Kehoe, M.D.; President, Russell E. Lynch, M.D., President-Elect, E. K. Isbey, M. D.; Secretary, E. J. Zabinski, M.D., and Treasurer, Peter Iacobell, M.D.

* * *

E. E. Sladek, M.D., Traverse City, Chairman of The Council of the Michigan State Medical Society, was honored in Atlantic City on June 11 by being made Vice Chairman of the Associated State Postgraduate Committees of the United States.

Congratulations, Dr. Sladek!

* * *

Robert M. Eaton, M.D., Grand Rapids, won the top prize offered by the American Association for Thoracic Surgery, in St. Louis, for his paper "Pulmonary Edema: Experimental Observation on Dogs following Acute Peripheral Blood Loss." Dr. Eaton was awarded the Rose Lampert Graff Foundation Prize of $250.

Congratulations, Dr. Eaton!

(Continued on Page 976)

INTERNATIONAL SURGICAL ASSEMBLY

UNITED STATES CHAPTER, INTERNATIONAL COLLEGE OF SURGEONS

PALMER HOUSE, CHICAGO, SEPT. 28, 29, 30, - OCT. 1, 2, 3, 4, 1947

President, Herbert Acuff, Knoxville, Tenn.; President-Elect, Custis Lee Hall, Washington, D. C.; Secretary, L. J. Gariepy, Detroit, Mich.; Chairman of Assembly, Raymond W. McNealy, Chicago.

ALL MEDICAL MEN AND WOMEN IN GOOD STANDING CORDIALLY INVITED

Intensive Clinical and Didactic Program by World Authorities

Cook County Hospital Day—Friday, October 3, 1947—9 a.m. to 5 p.m.
Special Chicago Hospital Clinics (21)—Saturday, October 4, 1947

Special Events—October 1, 1947—BANQUET—Palmer House Ballroom—6:30 p.m.
October 2, 1947—DEDICATION of Home of US Chapter of ICS—8 p.m.
October 3, 1947—CONVOCATION—Stevens Hotel Ballroom—8 p.m.

Following is a list of members of the profession who will take part in the program.

Adson, Alfred W., Rochester, Minn.
Anderson, Roger, Seattle, Wash.
Bailey, Hamilton, London, England
Bartlett, Willard, Jr., St. Louis, Mo.
Bates, Wm., Philadelphia, Pa.
Blady, John V., Philadelphia, Pa.
Berg, Albert A., New York, N. Y.
Callahan, James J., Chicago, Ill.
Cannaday, John E., Charleston, W. Va.
Cole, Warren, Chicago, Ill.
Collins, Donald C., Hollywood, Calif.
Compere, Edward L., Chicago, Ill.
Cope, Zachary, London, England
Counseller, Virgil, Rochester, Minn.
Chandler, Fremont A., Chicago, Ill.
Crossman, L. W., New York, N. Y.
Darget, Prof., Raymond, Bordeaux, France
Douglass, Fred, Toledo, Ohio
Dragstedt, Lester, Chicago, Ill.
Falls, Frederick, Chicago, Ill.
Furlong, Thomas, Ardmore, Pa.
Gillis, Leon, Roehampton, England
Greenhill, J. P., Chicago, Ill.
Hughes, Basil, Cornwall, England
Ivanissevich, Ambassador Oscar, Buenos Aires
Ivy, Andrew C., Chicago, Ill.
Jackson, Arnold, Madison, Wis.
Jackson, Chavalier L., Philadelphia, Pa.
Jenkins, Hilger Perry, Chicago, Ill.
Lewin, Philip, Chicago, Ill.
Lodge, Wm. Oliver, Halifax, England
Lord, Jere, Jr., New York, N. Y.
Lovelace, W. R. II, Albuquerque, New Mex.
MacCarty, Wm. Carpenter, Sr., Rochester, Minn.
Mandl, Prof. Felix, Jerusalem, Palestine
Maxeiner, Stanley R., Minneapolis, Minn.
McKittrick, Leland S., Boston, Mass.
Nissen, Rudolph, New York, N. Y.
Novak, Emil, Baltimore, Md.
Oberhelman, Harry A., Chicago, Ill.
Potts, Willis J., Chicago, Ill.
Pick, John F., Chicago, Ill.
Rios, J. Almeida, Rio de Janeiro, Brazil
Roman, Desiderio, Philadelphia, Pa.
Rosser, Curtice, Dallas, Texas
Sisson, August Maria, Porto Alegre, Brazil
Spain, Alex W., Dublin, Ireland
Stein, Irving F., Jr., Chicago, Ill.
Steindler, Arthur, Iowa City, Iowa
Swanson, Admiral Clifford, Washington, D. C.
Argentina-Watts, James W., Washington, D. C.
White, Charles, Washington, D. C.

Hotel Headquarters. Palmer House, Chicago—FOR HOTEL RESERVATIONS write Dr. Francis D. Wolfe, Chairman, Housing Committee, International College of Surgeons, 33 North LaSalle St., Chicago 2, Illinois.

Any doctor of medicine who uses surgery in his practice will find this meeting of great value. A program will be mailed to every member of the medical profession in good standing in the United States and Canada upon request to the Secretary about September 10.

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(Continued from Page 972)

The Upper Peninsula Medical Society meeting of June 27-28 at the Four Seasons Club, Pembine, featured the following speakers: F. A. Coller, M.D., Ann Arbor; Hardy A. Kemp, M.D., Detroit; C. G. Johnston, M.D., Detroit, Joseph W. Gale, M.D., Madison, Wisconsin; Raymond W. Waggoner, M.D., Ann Arbor, and M. E. Davis, M.D., Chicago.

* * *

J. O. Thomas, M.D., of North Branch, and *H. E. Randall, M.D.,* of Flint, were guests of honor at a banquet given Thursday evening, May 22, by the Lapeer County Medical Society, in honor of their completion of fifty years of service in the practice of medicine.

R. W. Waggoner, M.D., Ann Arbor, was speaker of the evening. More than fifty guests were present at the meeting.

* * *

The Detroit Dermatological Society on May 20, 1947, elected the following officers for the year 1947-1948: President, Arthur C. Curtis, M.D., First National Bank Building, Ann Arbor; President-Elect, C. E. Reyner, M.D., Ford Hospital, Detroit; Secretary-Treasurer, Herbert H. Holman, M.D., 2010 David Broderick Tower, Detroit, and Recorder, Herman Pincus, M.D., 120 Maple Boulevard, Detroit.

* * *

William G. Wight, M.D., who has practiced in Yale, Michigan, for over 50 years, was honored in the WJR (Detroit) broadcast "In Our Opinion" of June 29. The WJR News Director, George Cushing, went to Yale with the program, which indicated the important role such a man as Dr. Wight plays in his community. Assisting in the broadcast were a group of Dr. Wight's young and old patients and his son, Frederick B. Wight, M.D., of Detroit.

* * *

World War II Veterans who have decided upon a medical career and desire to learn their possibilities of success are being given a six-part scholastic text provided by the Veterans Administration. The veteran is given a preliminary sheet and a four-page booklet to read, after which questions on the technical material therein are asked. The booklet is divided into six sections: Scientific Vocabulary; Premedical Information; Visual Memory; Memory for Content; Comprehension and Retention; and Understanding of Printed Material.

* * *

The Board of Examiners in Basic Sciences announces its next examinations will be held October 10 and 11, simultaneously in Detroit and Ann Arbor. The following states have full reciprocity with Michigan's Board of Examiners in Basic Sciences: Arizona, Minnesota, and Nebraska.

The following have partial reciprocity with Michigan's Basic Science Board, in that the Michigan Board recognizes five of the subjects examined in the following states, but requires the applicant to take an examination in the

(Continued on Page 980)

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(Continued from Page 976)

sixth subject in Michigan, before receiving his certificate: Arkansas, Colorado, New Mexico, Oklahoma, Oregon, Rhode Island, and South Dakota.

* * *

The St. Clair County Medical Society acted as host at St. Clair Inn, St. Clair, Michigan, on June 20, at its annual spring meeting. Speakers on the program were Jean Paul Pratt, M.D., Detroit, and L. R. Haas, M.D., Ann Arbor.

The Society honored five of its members who have been in practice fifty years or more, on the occasion of the dinner following the Clinic: A. B. Armsbury, M.D., Marine City; J. A. Attridge, M.D., Port Huron, A. L. Callery, M.D., Port Huron; C. McCue, M.D., Goodells; and W. G. Wight, M. D., Yale.

T. E. DeGurse, M.D., Marine City, Councilor of the Seventh District, acted as Toastmaster.

* * *

"*It is true* that a human life is priceless, and that discovery of a case of cancer in a curable stage is worth any amount of money and effort. But this philosophy can be applied to only one person. If you apply it to everybody, you run into the difficulty that time and money are available in only finite amounts and must be allocated to all the other essential things of living.

"At present, cancer detection clinics must be looked on as pilot plants to explore: (a) the statistical success attainable in detection, and (b) the amount of medical talent available to be deviated to this effort."—R. R. Newell, M.D., in *Monthly Newsletter* of American College of Radiology, July, 1947.

* * *

Students for Rural Medicine.—The Liaison Committee of the Michigan State Medical Society with President Ruthven, met in Lansing June 19, 1947, when a report was given on the appropriation made by the Georgia Legislature to encourage farm boys to study medicine and to practice in rural areas for five years following medical graduation.

The recent survey of Michigan hospitals was discussed.

Dean O. C. Furstenberg reported on the following activity of the University of Michigan Medical School:

1,164 students in the Medical School.
787 Doctors of Medicine are taking intramural courses in Ann Arbor.
1,830 Doctors of Medicine are attending extramural courses.
119 research projects are under way.
700-800 patients are being served in the University hospital.

The problem of general practice and how to make it more attractive for young men was generally discussed. Dr. Furstenberg stated that the decentralization program of medical education of specialists is now under way with the accrediting of certain out-of-state hospitals for the education of the young men. Sixteen hospitals are prepared to serve specialists and eighteen hospitals are ready to give a good two-year residency, six months of the twenty-four being given at the University for the study of the basic sciences. Dr. Furstenberg reported

(Continued on Page 984)

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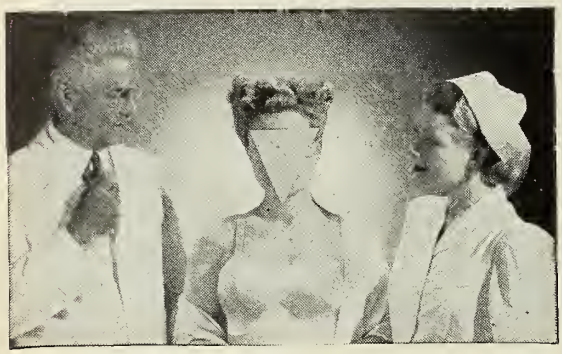

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(Continued from Page 980)

that 30 per cent of the graduates in the University of Michigan Medical School were interested in general practice, provided the University gives them hospital facilities and training opportunities.

* * *

Hospital Survey and Construction Act.—The Michigan Implementation Bill (H.B. 451) of the U. S. Hospital Survey and Construction Act, which bill was passed by Michigan's 1947 Legislature, contains the following important features:

1. An appropriation of $25,000 for purposes of administering the Act.
2. An office of Hospital Survey and Construction to be established in the executive branch of the state department.
3. Administration of the act by a full-time salaried director appointed by the Governor.
4. Creation of a Michigan Hospital Advisory Council to advise and consult with the Director in carrying out provisions of this Act.

The Director is authorized—

(a) To make an inventory of existing hospitals, to survey the need for construction of hospitals, and on the basis of such inventory and survey, to develop a plan for the construction of hospitals which will, in conjunction with existing facilities, afford necessary facilities for furnishing adequate hospital, clinic and similar services to all people of the state.

(b) To submit the plan or program for hospital construction to the Surgeon General, after adequate publicity and hearings, for his approval.

(c) To prescribe minimum standards for maintenance and operation of hospitals which receive federal aid.

(d) To receive applications which conform with federal requirements.

(e) To review the construction program from time to time and submit modifications of State Plan, not inconsistent with requirements of the federal act, as he may deem advisable.

(f) To inspect and certify payment for construction in accordance with approved plans and specifications.

* * *

Welcome, Doctor!

The Michigan State Medical Society is happy to welcome the following newly elected members reported during the month of May, 1947, from the indicated component county medical societies:

Eaton County—Herman Van Ark, M.D., Eaton Rapids.

Grand Traverse-Leelanau-Benzie Counties—George S. Evseef, M.D., Traverse City; John D. Whitehouse, M.D., Traverse City.

Ingham County—John A. Cowan, M.D., Lansing; Pearl Hackman, M.D., Lansing.

Ionia-Montcalm Counties—Harold E. Reid, M.D., Belding; Robert E. Rice, M.D., Greenville.

Kent County—G. Donald Albers, M.D., Grand Rapids; Marenus Beukema, M.D., Grand Rapids; Law-

(Continued on Page 988)

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Invigorating

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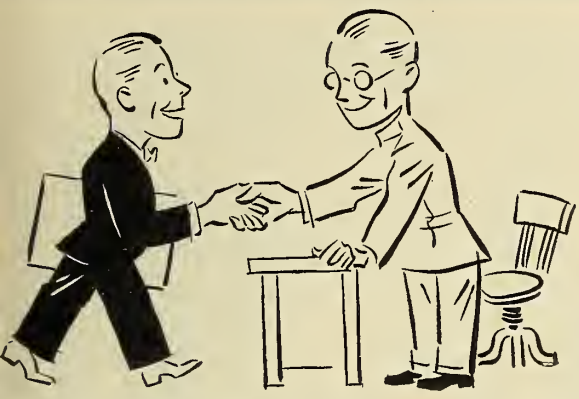

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(Continued from Page 984)

rence Bruggers, M.D., Grand Rapids; George Fahlund, M.D., Grand Rapids; Kenneth Gamm, M.D., Grand Rapids; Lawrence Hayes, Jr., M.D., Howard City; Robert E. Kelly, M.D., Grand Rapids; Chester M. Sidell, M.D., Grand Rapids; Robert B. Smith, M.D., Grand Rapids.

Shiawassee County—James Dillon, M.D., Perry.

Washtenaw County—John F. Preston, M.D., Ann Arbor; Herbert T. Schmale, M.D., Ann Arbor.

* * *

New features of the Afflicted Crippled Children laws as amended by the 1947 Michigan Legislature:

1. The doctor of medicine shall send itemized bill *direct* to the Michigan Crippled Children Commission Hollister Bldg., Lansing (not through the hospital, a in the past).

2. The Auditor General forwards the doctor's chec for services to his *professional address* (not to the hos pital, as in the past).

3. The top limitation on medical fees is ninety dol lars, a twenty per cent increase (payable in those countie where the local governmental fee schedule is not les than the MCCC fee schedule.)

4. Doctors of Medicine shall bill the Commission with in 60 days of the date services are rendered; bill received by the Commission after 60 days cannot b paid legally.

The new amendments to the Afflicted-Crippled Chil dren Acts become effective October 11, 1947.

* * *

HEARINGS ON S. 545

(Continued from Page 904)

services rendered, issues checks in payment therefor, ad vancing its own funds (to the extent of $341,248.50 o 3/31/47,) maintains permanent records of service re ports on microfilms, compiles, maintains and reports t Internal Revenue Department payments to individu physicians.

Billings to the Veterans Administration are made dail in the form required by the Veterans Administration.

Many other smaller incidental operations are carrie on in connection with the Veterans Administration Pr gram. It is submitted that the expense of the program the Veterans Administration is less than would be po sible otherwise to secure the same results, that Michiga Medical Service has billed considerably less than t expense percentage allowable, and as the program deve ops even that per cent will be reduced. The progra has been criticized for making possible abuse throu excessive utilization of services. It is interesting to no that from March 1, 1946, through August 31, 1946 31,060 treatments authorized by Veterans Administr tion through Michigan Medical Service, 66.13 per ce or 20,539 were rendered, 8.94 per cent or 2,777 were n presented to the physician by the veteran and 24.93 p cent or 7,744 were canceled unused by the physici as not required.

Examinations for pension or disability rating purpo are entirely under the control of the Veterans Admin tration and do not lend themselves to abuse by t physician.

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nervous and mental disorders, alcoholism and drug addiction
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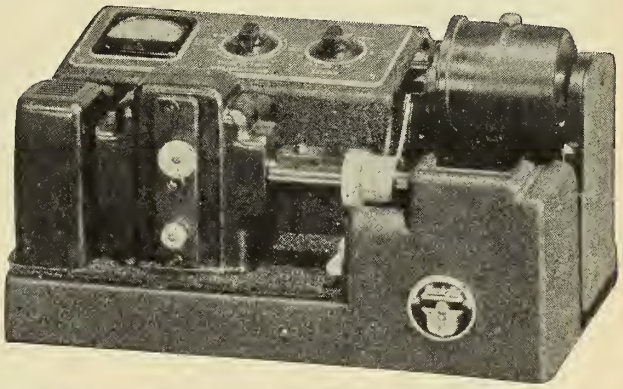

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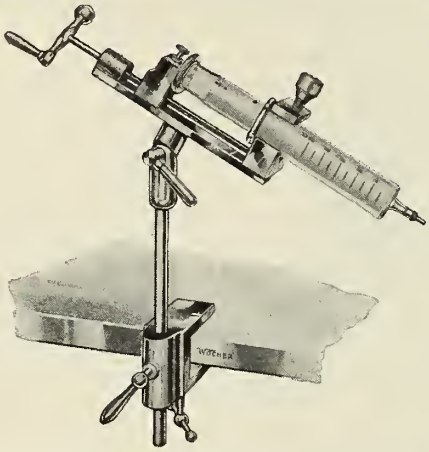

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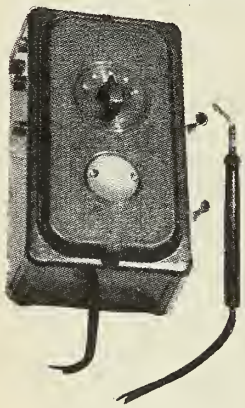

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Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

A TEXTBOOK OF PATHOLOGY. By E. T. Bell, M.D., Professor of Pathology in the University of Minnesota, Minneapolis, Minn. Contributors B. J. Clawson, M.D., Professor of Pathology in the University of Minnesota; J. S. McCartney, M.D., Associate Professor of Pathology in the University of Minnesota. Sixth edition, enlarged and thoroughly revised. With 500 illustrations and 4 color plates. Philadelphia: Lea & Febiger, 1947. Price $10.00.

Bell's sixth edition of his Textbook of Pathology has been extensively revised and new material added on tropical diseases as the result of war interest. Also vitamin deficiencies have a greater interest. The text is designed primarily for students, but holds complete interest for the practitioner. It is a well-prepared book, and is a recognized standard reference. It is a general pathology, giving comparatively little to the special fields of practice, such as eye, ear, nose and throat. Those looking for such special pathology will find other sources. An excellent general text.

DISEASES OF THE CHEST WITH EMPHASIS ON X-RAY DIAGNOSIS. By Eli H. Rubin, M.D., F.A.C.P., Attending Physician, Division of Pulmonary Diseases, Montefiore Hospital And Country Sanatorium, New York; Visiting Physician in Tuberculosis and Physician-in-charge, Chest Clinic, Morrisania City Hospital, New York. 685 pages, with 355 illustrations (24 plates in color). Philadelphia and London: W. B. Saunders Company, 1947. Price $12.00.

This book is written for general practitioners, tuberculosis specialists and x-ray men, giving them the practical things in diseases of the chest. Hundreds of chest pictures are given and analysed. Clinical features are correlated with chest findings and x-ray examinations. Diagnosis and treatment are quite extensively covered. Seemingly, there are references for every feature and fact mentioned.

A beautifully printed and profusely illustrated book. A credit to the shelves of every doctor interested medically or surgically in the chest.

SURGICAL PATHOLOGY. By William Boyd, M.D., M.R.C.P. Edin., F.R.C.P. Lond., M.D. Oslo, F.R.S.C. Professor of Patholoogy, The University of Toronto. Sixth Edition with 530 Illustrations including 22 Color Figures. Philadelphia and London: W. B. Saunders Company, 1947. Price, $10.00.

Advances in surgical and medical knowledge which resulted from the war years form important new additions to the sixth edition of Boyd's popular textbook for students and practitioners. An entirely new section has been added dealing with the pathology and pathological physiology related to the surgical treatment of congenital heart disease. The pathology of wounds and infections has been dealt with in a more comprehensive manner.

Thrombosis, thrombophlebitis and thromboembolism have occupied an important place in recent medical literature and are particularly well dealt with here with an explanation of the mode of action of Dicumarol and Heparin. The section on diseases of the thyroid gland is particularly good and includes the effect of Thiouracil on the pathological appearance of the thyroid gland, and response to its administration. Diseases of the

(Continued on Page 994)

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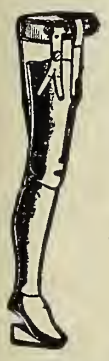

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Pictures and drawings of every type of structure found in the blood, with detailed outlines of proceedures in caring for the laboratory and laboratory equipment. Procedures are outlined 1, 2, 3, 4 and the findings interpreted. The colored plates alone are worth much more than the cost of the book as a guide to laboratory work.

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C. R. Keyport, M.D.....Grayling
P. L. Ledwidge, M.D.....Detroit
J. E. Livesay, M.D.....Flint
J. J. McCann, M.D.....Ionia
H. J. Meier, M.D.....Coldwater
F. J. O'Donnell, M.D.....Alpena
E. A. Oakes, M.D.....Manistee
E. S. Parmenter, M.D.....Alpena
C. A. Payne, M.D.....Grand Rapids
H. M. Pollard, M.D.....Ann Arbor
F. R. Reed, M.D.....Three Rivers
G. B. Saltonstall, M.D.....Charlevoix
R. W. Teed, M.D.....Ann Arbor
Arch Walls, M.D.....Detroit
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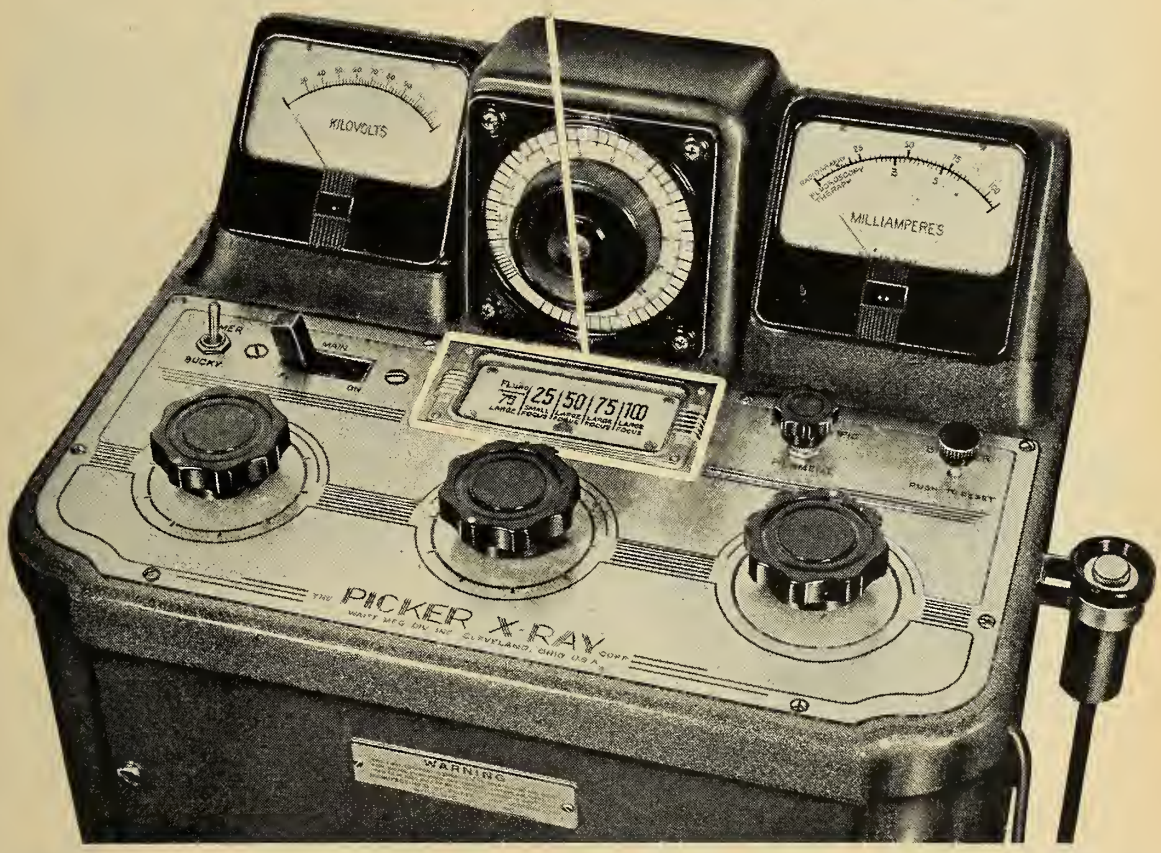

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(Continued from Page 1006)

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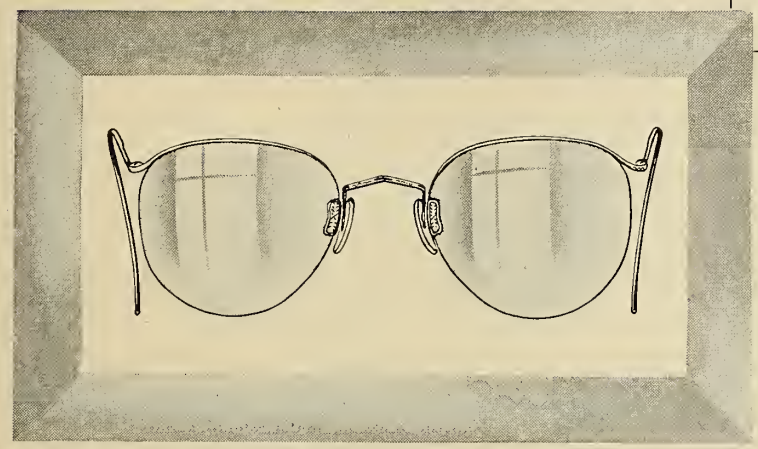

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UMW HEALTH FUND

The United Mine Workers' Health and Hospital Fund will be the subject of a joint meeting of the Councils on Medical Service and Industrial Health with the Board of Trustees of the AMA, next winter.

The AMA House of Delegates has approved the recommendations offered by the Council on Medical Service for implementing the Boone Survey. The first step will be to request formal conferences between representatives of the United Mine Workers and the Operators' Association and the American Medical Association and other related groups (such as the Association of Coal Mine Physicians, the American Hospital Association, the American Dental Association, the American Nurses Association, et cetera.

HEALTH CENTERS

What are they? Are the rules and regulations promulgated in Washington for construction of health centers and hospitals such that these facilities cannot be made available to those rural communities needing them most?

Last June, the AMA House of Delegates approved the following functions for health centers under the Hospital Survey and Construction Act: (1) communicable disease control efforts; (2) sanitation; (3) maternity-infant child hygiene measures; (4) vital statistics; and (5) health education.

Twenty-five states have enacted enabling legislation under the Hospital Construction Act and thirty-one states have had their plans and surveys approved.

PHYSICIANS IN RURAL AREAS—MISSISSIPPI PLAN

A scholarship fund has been provided by the Mississippi State Medical Education Board through loans to be made to GI's who wish to attend medical school. The maximum loan is $1,250 per year, and for each year spent in rural areas during early practice, a credit of one-fifth of the student's individual loan is allowed. This means that a physician on finishing his internship could pay his loan by practicing five years in rural areas in Mississippi.

Thirty-four of the sixty students attending medical school are using this state scholarship loan fund. Actually, it is not considered a money-lending proposition but is considered a program in the interests of the medical and hospital needs of the people of Mississippi who, in turn, are making possible the medical education of these physicians. It is interesting to note that seventeen of the thirty-four veterans are married and that ten have children. Twenty-eight of the veterans are white, and six are Negro, and they represent twenty-five towns in twenty-two counties.

THE G.P. BECOMES GENERALLY POPULAR

The General Practitioner was the outstanding theme at the 1947 AMA Annual Session in Atlantic City.

COMPULSORY HEALTH INSURANCE FURTHERED BY GOVERNMENTAL EMPLOYES

The Committee on Expenditures in the Executive Department, U. S. Congress, states in its Third Intermediate Report of July 2, 1947:

"All the evidence before your committee indicates that these health workshops were planned, conducted, and largely financed with Federal funds, by a key group on the Government pay roll, who used the workshop method of discussion subtly to generate public sentiment in behalf of what certain witnesses and authors of propaganda refer to as socialized medicine. It is evident from the record that most of the planning was done by the Federal officials in Washington prior to each workshop conference and that each meeting was devoted to their own purposes—that of organizing pressure groups to agitate for compulsory health insurance, as then pending in Congress.

"The chairman of this meeting (health workshop held in Jamestown, N. D., September 27-30, 1946) was Dr. Mayhew Derryberry, Ph.D. of the United States Public Health Service. Apart from

(Continued on Page 1012)

DO YOU KNOW WHAT THESE SYMBOLS STAND FOR?

For centuries the owl has symbolized great knowledge and superior wisdom. "Wise as an owl" was a quip of Caesar's time. The canny bird was sacred to Minerva, Roman goddess of learning and of science. The natural assumption was that the owl acquired wisdom from his patroness.

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COMPULSORY HEALTH INSURANCE

(Continued from Page 1010)

Federal personnel, . . . no registered doctor of medicine was invited to participate."

Thomas Parran, Surgeon General, advises that the USPHS will not participate in any more discussion groups, pending clarification by the Department of Justice of the Service's legal position.

His statement ends: "Meanwhile, I continue to support completely the President's program as regards to the national health."

SINAI AGAINST POLITICAL MEDICINE—IN 1934

Nathan Sinai, Dr. P. H., Ann Arbor, made the following comment to the MSMS House of Delegates at its special session of May, 1934, when discussing "Mutual Health Service."

"Then comes the question of the $3,750,000,000 being applied to our taxes. I am not quite clear concerning the contention that it would be applied to taxation, because if there is anything in which the Committee has been interested it has been in keeping Mutual Health Service as a service out of taxation, out of public funds, because immediately you get public funds mixed up in the cost you get some form of public direction and that usually means some form of political direction. This is a program that the Committee has presented as one in which the professions will take complete direction and in which the public, as far as industry and the recipients of service are concerned, will have representation, because the public is putting up the funds and is entitled to that representation."

Judging by his recent activities in California and in Honolulu, Dr. Sinai has changed his attitude with a complete about face since 1934!

THE DOCTOR AND THE PUBLIC

The public is willing and anxious to hear the side of the medical profession in the profoundly disturbing problems which face us in the distribution of medical care. Nor is there any question of our responsibility for the socio-economic, as well as the scientific, side of our work. Actually, much has been done of which we as a profession can be exceedingly proud, but the public does not know about it, largely because we as doctors have not devoted time and energy to telling the story.

Set against the failure to make known the progress in the socio-economic aspects of medicine, within the framework of organized action which has given us scientific progress of the highest order, there is the work of those who believe that socialized medicine is desirable. Among them are many sincere people who have ways and the ability to make an impression upon large sections of the population. Aside from crackpots and social dreamers, I have found, for example, that many teachers believe in socialized medicine and compulsory health insurance and are imparting these beliefs to their pupils.

It is to the considerable credit of the American Medical Association that even before the recent war, the need for methods of helping defray the rising costs of medical care was recognized, and state medical societies were encouraged to develop plans for prepaid medical care. Many of you are familiar with the early history of the Michigan Medical Service, which has served as a model for many other plans of voluntary prepaid medical care, sometimes called by laymen voluntary health insurance. It has also served, to some extent, as a model for the Veterans Administration plan of "Home Town Medical Care." The threat of compulsory health insurance—still far from destroyed—was, of course, an important stimulus to the development of the various voluntary plans, but recognition of this important principle, particularly in catastrophic illness, is more than just a response to a threat. It is now widely accepted and is actually a social institution of increasing size and importance. Through the Council on Medical Service of the American Medical Association, the medical profession is taking a lead in this socio-economic field, just as it always has in the promotion of scientific medicine.

When the public realizes that the medical profession is as much concerned with strictly scientific medicine, much of the task of improving the present low state of medical public relations will have been accomplished.

We all have a story to tell. Let us get busy with the telling of it.—Frank G. Slaughter, M.D., Florida Medical Association, 73rd annual meeting, April, 1947.

BOARDS AND ORGANIZATIONS

There is misunderstanding and confusion when matters of medical responsibilities and who is who are being considered.

First, the *Council of the Michigan State Medical Society* is the responsible body in the interval of House of Delegates meetings. It carries on the economic policy and financial affairs of the Society, and the publication of The Journal. It consists of the Councillors of the sixteen districts, the President, President-elect, Secretary, Treasurer and Speaker of the House. The names in order are:

C. E. Umphrey, M.D., 1st District, Detroit; P. A. Riley, M.D., 2nd District, Jackson; Wilfrid Haughey, M.D., 3rd District, Battle Creek; R. J. Hubbell, M.D., 4th District, Kalamazoo; J. D. Miller, M.D., 5th District, Grand Rapids; R. C. Pochert, M.D., 6th District, Owosso; T. E. DeGurse, M.D., 7th District, Marine City; W. E. Barstow, M.D., 8th District, St. Louis; E. F. Sladek, M.D., 9th District, Traverse City (Chairman); F. H. Drummond, M.D., 10th District, Kawkawlin; Roy

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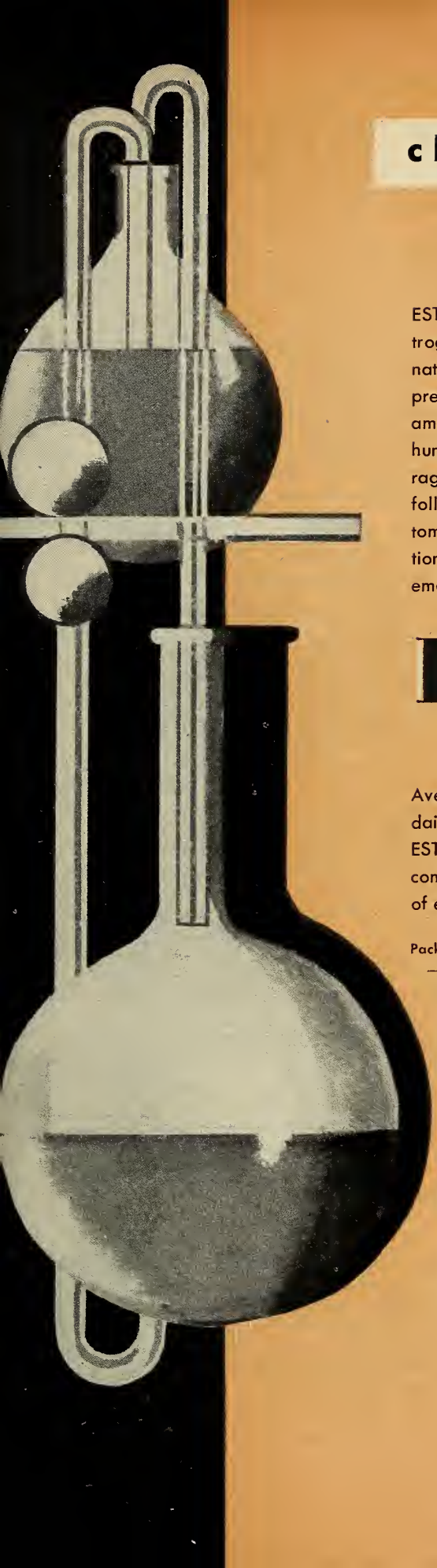

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1. Bickers, W.: Am. J. Obst. & Gynec. 51:100, 1946.
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BOARDS AND ORGANIZATIONS

(Continued from Page 1012)

Herbert Holmes, M.D., 11th District, Muskegon; A. H. Miller, M.D., 12th District, Gladstone; W. H. Huron, M.D., 13th District, Iron Mountain; D. W. Myers, M.D., 14th District, Ann Arbor; O. O. Beck, M.D., 15th District, Birmingham (Vice Chairman); E. R. Witwer, M.D., 16th District; J. S. DeTar, M.D., Speaker, Milan; W. A. Hyland, M.D., President, Grand Rapids; P. L. Ledwidge, M.D., President-elect, Detroit; L. Fernald Foster, M.D., Secretary, Bay City; A. S. Brunk, M.D., Treasurer, Detroit.

Michigan Medical Service is the non-profit medical service plan established by the Michigan State Medical Society. It is an independent corporation, the membership being the House of Delegates of the Michigan State Medical Society, plus elected non-medical officers of the organization. The corporation meets once a year and elects the Board of Directors who carry on the business and set the policies of the Service Corporation, furnishing prepaid medical, surgical and obstetrics service to its policy holders. The members of the Board are: Robert H. Baker, M.D., Pontiac; E. D. Barnett, M.D., Detroit; J. A. Blaha, Ironwood(resigned); Leon Bogart, M.D., Flint; A. S. Brunk, M.D., Detroit; E. I. Carr, M.D., Lansing; J. S. DeTar, M.D., Milan; Ernest H. Fletcher, Detroit; L. Fernald Foster, M.D., Bay City; Carlton Fox, D.D.S., Detroit; Robert Greve, Ann Arbor; W. B. Harm, M.D., Detroit; Wilfrid Haughey, M.D. (Vice President), Battle Creek; William A. Hyland, M.D., Grand Rapids; S. W. Insley, M.D., Detroit; Rev. Otis Jackson, Flint; P. L. Ledwidge, M.D., Detroit; Frank McAllister, Kalamazoo; R. L. Novy, M.D., Detroit (President); E. A. Oakes, M.D., Manistee; L. V. Ragsdale, M.D., Detroit; John Reid, Lansing; Philip Riley, M.D., Jackson; E. F. Sladek, M.D., Traverse City; Mrs. Dora Stockman, Lansing.

Michigan Hospital Service is the Blue Cross Service plan for hospitals in Michigan, organized by the Michigan Hospital Association with the aid of the Michigan State Medical Society, which nominates six members of the Board of Directors. The participating hospitals through the District Advisory Committees nominate fourteen hospital administrators or governing board members, who are automatically elected, and the Board of Hospital Service elects eight members, representing the public. Michigan Hospital Association, as such, has no representative on the Board. The MHS is also an independent corporation whose duties or functions are to operate a prepayment hospital service plan furnishing hospital service to its policyholders. The Board of Directors is: George M. Welch, Detroit (President); E. D. Barnett, M.D., Detroit (Vice President); Ralph E. Phelps, Detrait (Treasurer); James L. Dack, Graham L. Davis, Wilfrid Haughey, M.D., Battle Creek; O. O. Beck, M.D., Birmingham; Murl H. Defoe, Charlotte; Kenneth Babcock, M.D., A. S. Brunk, M.D., Fred M. Butzel, Rev. Bernard R. Crowley, Sr. Martina, John W. Paynter, I. R. Peters, William S. Reveno, M.D., Claire M. Sanders, E. R. Witwer, M.D., Detroit; Charles G. Watkins, Grand Rapids; R. E. Geoghegan, Highland Park; D. R. Smith, M.D., Iron Mountain; Walter S. Foster and Ray Potter, Lansing; Harold McB. Thurston, Muskegon; Erwin J. Geyer, Saginaw; Wm. S. McNary (Executive Vice President), Detroit.

There are overlapping memberships in two and three organizations, and there are overlapping functions, but in general all three organizations are and act independently. They make their own decisions, and carry on their own business. There are occasional joint meetings when mutual functions are to be discussed, but each organization acts its own will.

We have listed and outlined these boards of directors and organizations and functions in the hope that such a statement will clarify misunderstandings that arise, and will help our members to a better understanding of the tremendous mass of business, professional, economic and service matters incident to medical and hospital affairs in Michigan.

SUBSIDIZED MEDICINE

In the current "Kiplinger Magazine," a point is made about the glaring difference in the results of two polls on health insurance. One poll asked people if they would approve a 6 per cent deduction from wages for federal medical care and hospitalization. Only 16 per cent of the replies were favorable. Another poll asked if they approved of having social security cover doctor and hospital care. Sixty-eight per cent approved.

This is about the way people react to the subject. If they are asked to pay for having the government do something, they say no. If the inference is conveyed that they will get something for nothing, they are for it.

This love of something for nothing is what Roosevelt's New Deal exploited so successfully. It was a deliberate deception, but it had the pulling power of a beetle-trap.

When the war interrupted the New Deal in 1940, the next article on the agenda was what was euphoniously but fraudulently called "health insurance." The indefatigable Senator Wagner proposed, in 1939, an extension of social security to include what he called "national health insurance." The idea came to be embodied in what has been known as the Murray-Wagner-Dingell Bill. The bill and other proposals inspired by it were vigorously exploited. Battles were staged in congressional committees. The fight spilled out over the country into state politics, newspapers, medical and welfare associations, radio programs and so on.

The MWD bill has been unsuccessful so far—largely because of the overwhelming opposition of the medical profession and the organized work of the National Physicians' Committee, the spearhead of the American Medical Association.

But each year the MWD plan has reappeared, like Puck, in a new embodiment. If a certain feature meets stiff and convincing criticism one year, the next edition amends that feature. But no matter how much it is pruned, it is the same tree. It is not insurance, for it is not self-supporting. It is not collective medical care, for

(Continued on Page 1016)

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SUBSIDIZED MEDICINE

(Continued from Page 1014)

its beneficiaries do not pay for what they get. It is plainly government medicine, for the most part a handout which does not admit that it is charity.

The current edition of the bill, S.1320, contains the usual Wagneresque overture of sententious purpose. It proposes a vast range of services for practically everyone who wishes free service and his dependents. It covers all sorts of medical, dental, nursing and hospital services. In part, it would be paid for by a tax on wages and on payrolls and, in part, by general taxation. Its ramifications go into state and local public health, into hospitals, private voluntary health associations and the like.

Such a setup, of course, involves a New Dealer's delirium of bureaucracy. Administrators, federal, state and local committees, councils and advisers abound, as well as fact-finding—to the tune of millions.

Nothing was ever conceived or devised which would more effectively reduce the medical profession to dependence on the government and tie state and local agencies to the wheels of the federal government.

The bill has no chance of passage this year, but it may well be the keystone of next year's Democratic platform. *It is a threat which deserves far more public attention than it has yet been receiving.*—Raymond Moley, *Chicago Journal of Commerce,* July 9, 1947.

POLIOMYELITIS CONSULTATIONS

The Michigan Crippled Children Commission, in a letter to the secretaries of the local County Medical Societies and full-time health officers, announces it will again this year provide *poliomyelitis consultations* to physicians desiring them for cases or suspected cases of poliomyelitis in children from birth to twenty years of age, inclusive, where the family is *financially unable* to provide this service and where consultation is not furnished locally, such service to be effective until further notice. A pediatrician may be called for diagnosis before weakness or paralysis is established, following an orthopedic surgeon. Directions are given for making the request, and all information is on file with the health officer or the secretary of the County Medical Society.

We do not have space for listing the consultants or seventeen districts, seven typewritten pages, but these are on file in the offices of secretaries and health officers for anyone who is interested.

COMMISSION ON ORGANIZATION OF THE EXECUTIVE BRANCH OF THE GOVERNMENT

Senator Henry Cabot Lodge and Congressman Clarence Brown were sponsors of a bill, S. 164-H.R. 775, authorizing the appointment of a commission to streamline the Executive Department of the Government. The Committee which reported the bill said, "This measure authorizes the appointment of a *bipartisan commission* to study and investigate the present organization and methods of operation of the departments, bureaus and other divisions, as well as independent establishments and instrumentalities, of the executive branch of Government to determine what changes therein are necessary, or will be beneficial, in their opinion, to bring about greater economy and efficiency in the public service by (1) limiting expenditures to the lowest amount consistent with the efficient performance of essential services, activities, and functions; (2) eliminating duplication and overlapping of services, activities, and functions; (3) consolidating services, activities, and functions of a similar nature; (4) abolishing services, activities, and functions not necessary to the efficient conduct of government; and (5) defining and limiting executive functions, services, and activities."

The necessity for a study such as this Commission is charged to make is demonstrated in the following paragraph taken from the Senate's report of the bill:

"During the past sixteen years, national and international events have necessitated a constantly expanding emergency government. In the wake of the prolonged economic distress of the 1930's and the four years of direct participation in World War II, the number of principal components of the Federal Government have multiplied from 521 in 1932, to 2,369, in 1947. The annual pay roll of the executive branch of the Government today approximates 6¼ billion dollars which is 1½ billion dollars more than the Government spent for all purposes in 1933. The executive branch now employs more people than all the State, city, and county governments combined. In this sprawling organization called the United States Government, functions and services criss-cross and overlap to a degree which has astounded every student of governmental operation. For example, there are no less than twenty-nine agencies lending Government funds, thirty-four engaged in the acquisition of land, sixteen engaged in wildlife preservation, ten in Government construction, nine in credit and finance, twelve in home and community planning, ten in materials and construction, twenty-eight in welfare matters, four in bank examinations, fourteen in forestry matters, and sixty-five in gatherings statistics. Excluding the Army and the Navy, there are more Federal employes on the pay roll today than on V-J Day. And all the evidence points towards still further expansion, aimlessly, pointlessly, pleasing no one and frustrating sincere efforts to serve the people. The cessation of hostilities has brought little reduction in the tremendous war expansion of the Government.

"In its annual evaluation of Government budget estimates, the Congress and its committees are constantly faced with a well-nigh insoluble dilemma. In striving to strike an equitable balance between justifiable expenditures and imperative economy, the conscientious search for the necessary facts more often than not leads up dead-end paths or becomes enmeshed in a maze of confusion and doubt. In attempting to preserve essential functions, the basic question always arises: *What functions are essential?* For example, if the chief of each of the 29 Government lending agencies were asked: 'Is your agency essential?' the answer in each case would certainly be 'Yes.' Yet no reasonable man could believe that 29 agencies of this type are essential to the efficient operation of our Government. But no overall authority

(Continued on Page 1018)

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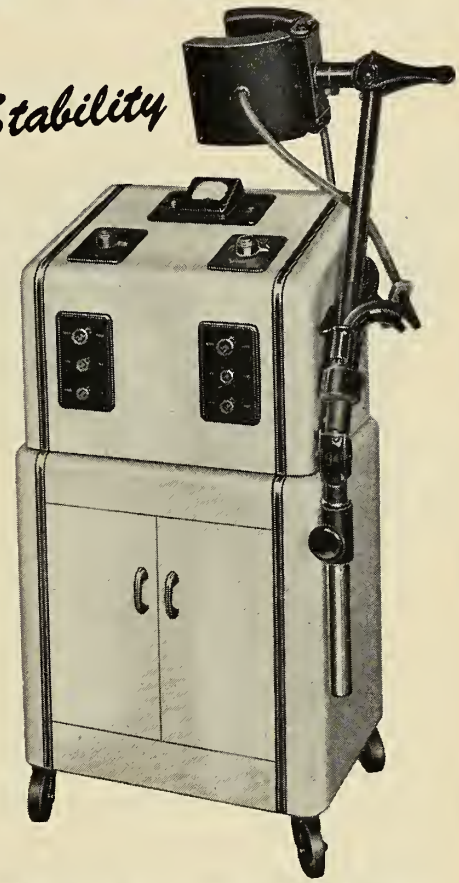

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EXECUTIVE BRANCH OF THE GOVERNMENT

(Continued from Page 1016)

is available to answer the question. There is nobody who can tell us in detail, and with informed authority, just where we can consolidate, or where we can eliminate, or where, if necessary, we must expand. This situation forces Congress to swing the meat ax rather than manipulate the surgeon's scalpel. Efficient economy cannot be predicated on guesswork, no matter how sincere the effort. Efficient and economical government can be the product only of painstaking study and authoritative analysis."

The Commission is to make a report of its findings and recommendations within ten days after the 81st Congress is convened and organized in January, 1949. Ninety days after the filing of their report the Commission automatically goes out of existence.

The Commission is composed of the following twelve members.

Selected by President of Senate.—Dr. James K. Pollack, University of Michigan; Joseph P. Kennedy, former U. S. Ambassador to Great Britain; Senator George D. Aiken, Vermont; Senator John L. McClellan, Arkansas.

Selected by the President.—James Forrestal, Secretary of the Navy; Arthur S. Fleming, Civil Service Commissioner; Dean Acheson, former Undersecretary of State; George H. Mead, Dayton, Ohio, industrialist.

Selected by Speaker of House.—Herbert Hoover, former President of United States; James H. Rowe, former Assistant to President Roosevelt and Assistant to Attorney General; Congressman Carter Manasco, Alabama; Congressman Clarence J. Brown, Ohio.

ARMY MICROFILM EXHIBIT AT PEDIATRIC CONGRESS

Newest examples of microfilm duplication of the nation's greatest collection of medical literature were on display at the Fifth International Congress of Pediatrics meeting at the Hotel Waldorf Astoria, July 14-17, 1947.

The feature exhibit is sponsored by the Photoduplication Division of the Army Medical Library, branch of the Office of the Surgeon General, U. S. Army.

A treasure chest of medical information, going back in some cases to medieval times, the Army Medical Library in Washington now has a collection of more than 1,000,000 volumes that have been gathered, catalogued and indexed since 1836 when Surgeon General Joseph Lovell began the work during the administration of President Andrew Jackson.

Through the microfilm service of the Army Medical Library, physicians, libraries and professional workers almost anywhere in the world may obtain facsimile replicas of this great bulk of existing medical literature on 35 millimeter film.

Any page of a medical journal, book or manuscript is photographed with high-speed cameras in the microfilm process. The physician or researcher requesting the material receives the film reproduction reduced to the size of a large postage stamp for each page. These pages can be read either in small size film viewers which enlarge the tiny microfilm, or they can be projected to large, readable size in special machines now available in many libraries and research centers. A whole book on microfilm takes only as much space as the corner of a coat pocket.

During the year 1946, over 6,000,000 pages of medical literature were distributed on 551,102 feet of microfilm.

From a doctor in the Belgian Congo came an urgent request for a complete bibliography on the nutritional merits of soy beans, peanuts and cottonseed. From France came a request for medical reports on injuries in parachute jumps. Two sources in South Africa sought medical information available only in Japanese medical literature. In addition, thousands of physicians and other professional workers in the United States sought complete facsimile bibliographies on hundreds of specific medical subjects.

Costs are moderate for the microfilm duplicating service that brings the world's medical literature into the office of any physician however remote. Articles in medical periodicals are duplicated on microfilm for fifty cents each. Books are duplicated for fifty cents for each fifty pages or fraction thereof. Photostats are priced at fifty cents for each ten pages or fraction thereof for any single volume. There are certain restrictions on photoduplication to protect the rights of copyright owners.

MEDICAL SOCIETY EXECUTIVES CONFERENCE

Eighty physicians and laymen, who serve as executive officers of national, regional, state, or county medical societies or associations throughout the United States, became charter members of the Medical Society Executives Conference at the first annual meeting of the organization in Atlantic City on June 11, 1947.

Mr. Mac F. Cahal, executive secretary and general counsel of the American College of Radiology, Chicago, was elected Chairman of the organization for the ensuing year. Other officers elected at the first meeting were Mr. R. R. Rosell, executive secretary of the Minnesota State Medical Society, Vice-Chairman; and Mr. James R. Bryan, executive secretary of the Medical Society of the County of New York, Secretary and Treasurer. To serve with these officers on the executive committee, the Conference elected Dr. George F. Lull, secretary and general manager of the American Medical Association, and Mr. Theodore Wiprud, executive secretary of the Medical Society of the District of Columbia.

In a brief business session following registration in mid-afternoon, the conference adopted a statement of organization setting forth the purpose of this organization as being "to enable medical society executives to improve the quality and efficiency of their services to their respective societies and to the medical profession generally; to provide a mechanism for the exchange of information and experience among medical society executives, for mutual improvement and for fellowship."

The membership qualifications, as approved by the Conference, make membership available "to executive

(Continued on Page 1020)

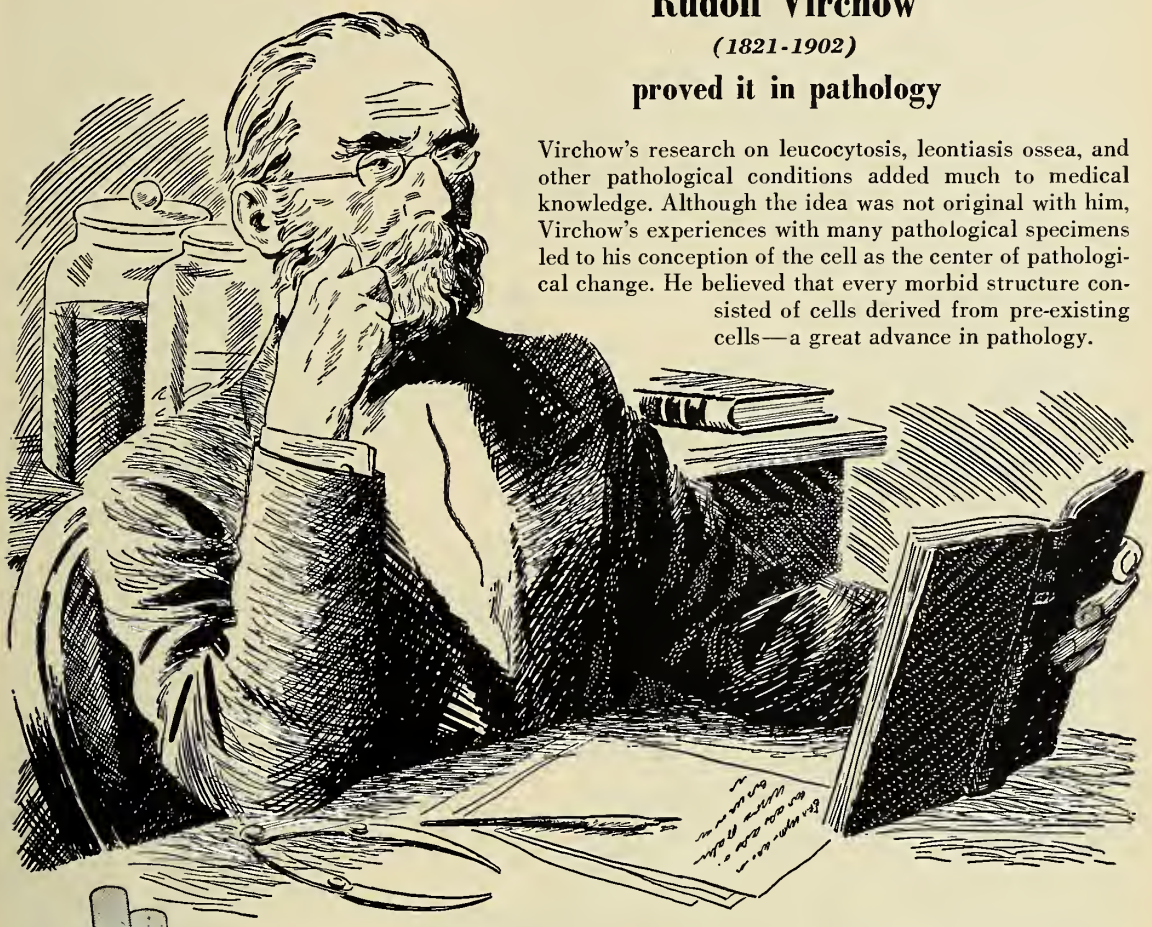
Experience is the Best Teacher

Rudolf Virchow

(1821-1902)

proved it in pathology

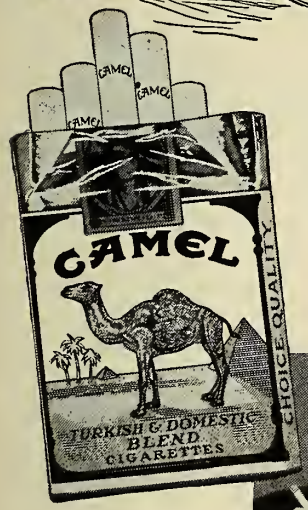
Virchow's research on leucocytosis, leontiasis ossea, and other pathological conditions added much to medical knowledge. Although the idea was not original with him, Virchow's experiences with many pathological specimens led to his conception of the cell as the center of pathological change. He believed that every morbid structure consisted of cells derived from pre-existing cells—a great advance in pathology.

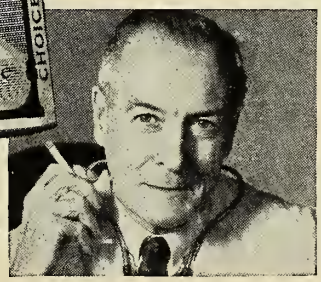


Yes, and experience is the best teacher in smoking too!

EXPERIENCE during the wartime shortage taught smokers the differences in cigarette quality. Millions of people smoked more different brands then than they would normally have tried in years. More smokers came to prefer Camels as a result of that experience, so that today more people are smoking Camels than ever before.

But, no matter how great the demand, we don't tamper with Camel quality. Only choice tobaccos, properly aged, and blended in the time-honored Camel way, are used in Camels.





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Winston-Salem, N. C.

MEDICAL SOCIETY EXECUTIVES CONFERENCE

(Continued from Page 1018)

employes of national, state, regional and county medical societies who are compensated for their services by their respective societies."

Meetings of the Conference are to be held concurrently with each annual meeting of the A.M.A. or at such other times as the executive committee may provide.

Following the executive meeting the following program was presented:

1. "The Standardization of Membership Records of Medical Societies."—Frank Cargill, Manager, Directory Department, American Medical Association.
2. "A Program Director's View of Medical and Health Radio Programs"—Dwight Herrick, Manager, Public Service Department, National Broadcasting Company.
3. "What a City Editor Looks For in a News Release" —William Hill, City Editor, *Washington Evening Star.*
4. "The Technique of Executive Management"—Martin Lasersohn, M.D., Vice President, Winthrop Chemical Company.

Application for membership, together with advance payment of dues for the current year should be sent to Mr. James E. Bryan, Secretary-Treasurer, Medical Society Executives Conference, Room 553, 2 East 103 Street, New York 29, N. Y.

The next meeting of the Medical Society Executives Conference will be held in Chicago during the week of the American Medical Association meeting in June of 1948.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The annual meeting of the American Board of Obstetrics and Gynecology was held in Pittsburgh, Pennsylvania, from June 1 to June 7, 1947, at which time two hundred and fifty candidates were certified.

A number of changes in Board regulations and requirements were put into effect. Among these is the new ruling that the Board does not subscribe to any hospital or medical school rule that certification is to be required for medical appointments in ranks lower than Chief or Senior Staff of hospitals, or Associate Professorship in Schools of Medicine, for the obvious reason that such appointments constitute desirable specialist training. At this meeting the Board also ruled that credit for graduate courses in the basic sciences which involve laboratory and didactic teaching rather than clinical experience or opportunities will be given credit for the time spent up to a maximum period of not more than six months regardless of the duration of the course.

The next written examination (Part I) for all candidates will be held in various cities of the United States and Canada on Friday, February 6, 1948, at 2:00 P. M.

Applications are now being received for the 1948 examinations. Closing date for these applications will be November 1, 1947.

For further information and application blanks, address Paul Titus, M.D., Secretary, 1015 Highland Building, Pittsburgh 6, Pennsylvania.

RESOLUTIONS—GENESEE COUNTY MEDICAL SOCIETY

The Genesee County Medical Society is opposed to any group, including Michigan Medical Service and Michigan Hospital Service, advertising in any way that purports to speak for the Doctor, or in the name of the Doctors unless such advertising conforms to the principles of the American Medical Association, namely, that it be honest, informative and educational.

Therefore, BE IT RESOLVED, that the Genesee County Medical Society is opposed to the publishing of such advertising in Genesee County unless it has been previously submitted to the County Medical Society, and its approval and endorsement secured.

Further, should such advertising be published in any media in Genesee County, the Genesee County Medical Society will authorize the expenditure of funds necessary to refute such exaggerated statements.

WHEREAS, the Michigan Hospital Service was created with the aid and approval of the Doctors of Medicine of the State of Michigan, and

WHEREAS, the intimate association of the Michigan Hospital Service and the Michigan Medical Service has created the belief among the people of this State that they act for and with the consent of the Doctors of Medicine of Michigan, and

WHEREAS, the acceptance of hospitals which do not conform to the standards of the American Medical Association, the American College of Surgeons, and the American Hospital Association, as full participating hospitals has created the impression that the acceptance of such hospitals has the approval of the Doctors of Medicine of this State, and

WHEREAS, such actions by Michigan Hospital Service in approval of these hospitals was taken without consideration or approval of the Doctors of Medicine of Michigan.

Therefore, BE IT RESOLVED, that the Genesee County Medical Society condemns such action of Michigan Hospital Service on the basis that it is inconsiderate, arbitrary, contrary to the high standards of the medical profession and detrimental to the medical welfare of the people of the State of Michigan.

Further, BE IT RESOLVED, that a copy of this resolution be sent to the Presidents of Michigan Hospital Service, Michigan Medical Service, the Michigan State Medical Society, the Chairman of the Council of the Michigan State Medical Society, the Councilor of each District, the Insurance Commissioner of the State of Michigan, and to the Secretary of each County Medical Society of the State of Michigan.

BENADRYL may frequently afford an economical alternative to long journeys to expensive resorts in "pollen-free" areas.

It is now established that the symptoms of anaphylaxis are usually the result of an excessive amount of histamine in the tissues. By antagonizing this substance, BENADRYL frequently renders the patient free of the symptoms of allergy. From 25 to 50 mg. are usually sufficient to produce relief.

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Michigan Foundation for Medical and Health Education

President's Report

By Earl Ingram Carr, M.D., Lansing

The business of the past quarter has been largely directed towards distribution of the large brochure, "Leading in Learning," to every practicing doctor of medicine in Michigan, to principal officers of state medical societies, to selected bank and trust company officers and attorneys and to interested doctors and individuals for specific uses.

An artistic pocket-size folder entitled "Invest in Health," for wide and general distribution by doctors and by others to their friends and patients, has been developed and 15,000 of these, at a production cost of about $450.00, are being printed. We thank Mr. Brenneman for his aid in this also.

We are providing for fund raising energetically and variously. But, we must have in mind that there is another need beyond single gifts to the Foundation. There is a need to secure repeated or, if possible, annual contributions from as many sources as we are able to obtain. If considerations, some of which are to follow in this communication, are accepted, the necessity for annual income over and above earnings on investments will be apparent.

Furthermore, your president is becoming increasingly aware that the Michigan Foundation is losing its newness, and the time is at hand to show some degree of action, even if it is not particularly large. The Foundation must show support and financial backing to popular projects to further win and maintain general favor.

For example, we assumed the luncheon program for the Annual County Secretaries 1947 Conference for the MSMS and provided Governor Kim Sigler as the speaker upon the subject of "Michigan's Role in Medicine." The Governor's address appears as the first article in the April issue of The Journal MSMS. After luncheon, two sections were formed and were addressed by Trustees B. R. Corbus and J. M. Robb to disseminate information to carry back to the counties on the subject of the Foundation.

For another example, we have acted as co-sponsors of the recently created Michigan Postgraduate Clinical Institute, joining with the University of Michigan Medical School, the Wayne University College of Medicine, the Department of Postgraduate Medicine of the University of Michigan and with the Wayne County Medical Society to support the Michigan State Medical Society in this pioneering educational promotion.

In another instance, your president accepted an invitation to a meeting of representatives from many Michigan education groups called by the MSMS Rural Health Committee, and he responded to the subject requested of him in behalf of the Foundation. The result of this meeting was universal agreement for a Michigan Rural Health Conference similar to the national conference recently held in Chicago at which state planning was urged.

The Auxiliary of the Michigan State Medical Society has elected to take on as a project the Michigan Foundation to publicize and to aid in fund raising. They have made a place for the Foundation in their annual program in September at Grand Rapids and have invited the president to appear.

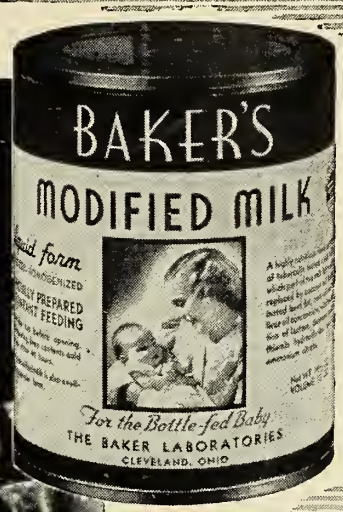
Your president has given attention to a research on medical care in rural areas proposed and planned by representatives of the Department of Sociology of the Michigan State College. MSMS has already subscribed a cash contribution towards the expense of this course and another $5,000.00 is needed to augment this State College enterprise.

A plan already has been established in Michigan, with the approval of the AMA, of the special colleges (ACS, et cetera) and of the fifteen American Boards for Specialists, for four years' training following graduation in medicine in out-state accredited hospitals to be affiliated with the two medical schools. This plan provides an internship in the out-state hospital for the first year, a continuation in the same hospital as assistant resident the next year, attendance at the medical school for courses and training in basic sciences for the third year, and a return to the original hospital as resident in a chosen specialty for the fourth year. A co-ordinator has been selected

(Continued on Page 1024)

Presented to the Foundation's Board of Trustees, May 21, 1947.

THE *End Results* ARE WHAT COUNT



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These are "end results" of the years of research back of Baker's Modified Milk.

What the attainment of these results means to doctors is attested by the steadily increasing use of Baker's Modified Milk, which is advertised only to the medical profession. More and more doctors are prescribing Baker's Modified Milk because they find Baker's produces desired results with less trouble in most cases of infant feeding... that no change in dilution is needed as the baby grows older (just increase the quantity of feeding) . . . and the possibility of errors—always present when formulas are prepared in the home—is avoided.

To prepare Baker's for feeding merely dilute it to the prescribed strength with water, previously boiled. Baker's is available in both powder and liquid forms. Formulas made from liquid Baker's are especially easy to prepare; in some cases, such as the lack of refrigeration in hot weather, or when traveling, the powder form is preferable.

Doctors and hospitals are invited to write for full information and samples.

• Baker's Modified Milk is made from tuberculin-tested cows' milk in which most of the fat has been replaced by animal and vegetable oils with the addition of lactose, dextrose, gelatin, iron ammonium citrate, vitamins A, B1 and D. Not less than 400 units of vitamin D per quart.

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THE BAKER LABORATORIES, INC., CLEVELAND, OHIO BRANCH OFFICES: SAN FRANCISCO, LOS ANGELES and DENVER

Editorial Comment

HEALTH IS NOT ON THE MARKET

Most people are misled by the term "health insurance." They picture an attractive system, which, for a nominal fee, will eliminate most of the ills the human flesh is heir to. This is responsible for much of the support to schemes for compulsory government "health insurance."

You can buy prepaid hospital and medical care. Throughout the country many excellent volunteer plans to accomplish this are in effect, they are spreading rapidly, and their cost is remarkably low for the services rendered. But you can't buy anything that will guarantee health. The public health is dependent on any number of factors outside the province of doctors and hospitals—sanitation, personal hygiene, accident prevention, nutrition, housing, crime control, working conditions, and family income. No concern, not even the government, can write a policy guaranteeing that all these conditions will be immediately solved.

The government can, of course, force payment in advance for medical services. It can regiment the medical profession and make the doctor dependent on political favor and patronage for his income. This has been tried in England, the Scandinavian countries, and elsewhere, with dubious results. It is certainly true that no nation receives better medical care than ours, under the present voluntary system.

The cheerful words "health insurance" should not be permitted to lead us to an experiment which would end in socialized medicine.—Editorial, *The Journal-Lancet,* July, 1947.

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MEDICAL PLACEMENT

76 W. ADAMS **DETROIT 26**

MICHIGAN FOUNDATION FOR MEDICAL AND HEALTH EDUCATION

(Continued from Page 1022)

and has been establishing this plan for several months. The Kellogg Foundation has subscribed more than $100,000 in support of this plan and to provide for it.

Several important reasons have appeared to indicate not only the wisdom but the necessity for another concentrated plan which would entail two years instead of four. Two of these are:

1. Senior medical students have challenged the planners of training for an opportunity to train for general practice.

2. The out-state hospitals require a two-year service and cannot afford so many four-year positions as might result from the specialist plan alone.

Doctor Graham Davis of the Kellogg Foundation recently expressed to your president a willingness to support this plan also.

General practice is the backbone of American Medicine, and specialism cannot monopolize the practice of medicine without harming the individual and without jeopardizing the health of the public. The cults, in many communities, have replaced absented (in military service) and departed physicians. The AMA, the National Physicians Committee, the American Association of Physicians and Surgeons, and all national organizations which work to improve medical practice and to keep out government-controlled medical practice, regard the cultivation of general practice as the crying and burning need today of American Medicine.

Your president, then, has three proposals for action of the Foundation:

1. A contribution of $5,000 to the Michigan State College Research for Medical Care in Rural Areas.

2. To sponsor, with others, the Michigan Rural Health Conference which will entail no cash outlay.

3. To contribute some sum within our means for the training of general practitioners in the above described plan for internship and residency during the two years immediately following graduation.

The JOURNAL

of the Michigan State Medical Society

Issued Monthly Under the Direction of the Council

VOLUME 46 SEPTEMBER, 1947 NUMBER 9

Of Juvenile Court Justice and Judges

By Judge Paul W. Alexander

Toledo, Ohio

"If a man have a stubborn and rebellious son, that will not obey the voice of his father, or the voice of his mother, and, though they chasten him, will not hearken unto them; then shall his father and his mother lay hold on him, and bring him out unto the elders of his city, and unto the gate of his place; and they shall say unto the elders of his city, This our son is stubborn and rebellious, he will not obey our voice; he is a glutton, and a drunkard. And all of the men of his city shall stone him to death with stones."

This is the law as laid down by Moses a few thousand years ago in Deuteronomy XXI, 18-21. It is one of the first, if not the very first recorded pronouncement on the handling of the juvenile delinquent. Maybe the elders of the city constituted the original juvenile court. And this doctrine, with some modification of its severity, has largely prevailed down to comparatively modern times when, at the turn of the present century, children were taken out of the adult criminal court and turned over to the juvenile court as we know it.

"As we know it." But do we know it? I often feel the juvenile court is the least understood and most misunderstood of all our legal institutions. This is hardly strange considering that our ordinary civil and criminal courts have been established for centuries in substantially their present forms and have become somewhat familiar to us, if not by personal experience as litigant, witness, juror or spectator, at least through the drama, movies, literature and the press. On the other hand, the juvenile court has barely shed its swaddling clothes and is just emerging into the growing-pain stage.

But after ten years of experience as a juvenile court judge, I find myself still the victim of a legal heresy: realistically and essentially the juvenile court (except to a limited degree) is not a court in the sense commonly accepted by both laymen and lawyers.

Just what is a court?

The man on the street would probably tell us it is a place where people go (or are taken!) to get justice—an agency for the administration of justice. And he would be fundamentally right. That is what most of our courts are doing, most of the time. But that is not what the juvenile court does. It is not an agency for the administration of justice to children. I don't mean that the juvenile court is not just to children. It is more than just to them!

Then what is justice?

Our prevailing concept of justice is barely two centuries old. Before that time, the courts didn't always administer justice as we know it today. If a man accused of crime happened to be wealthy or of the upper classes, he was apt to be let off with a figurative slap on the wrist. If, on the other hand, he happened to be a peasant or a poor man, he was apt to be punished with undue severity.

So when, about two centuries ago, the idea was propounded by Beccaria, among others, that all persons always should be treated alike, whether rich or poor, nobleman or peasant, it was hailed as a great step forward. The court must treat

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Read at the "Child Guidance Meeting," of the Michigan Society of Neurology and Psychiatry, February 20, 1947, Detroit, Michigan.

Judge Alexander is from the Court of Common Pleas, Division of Domestic Relations and Juvenile Court, County of Lucas, Toledo, Ohio.

everybody alike. Justice must be even-handed. The court must no longer look at the individual. It must look only at the offense. It must be blind to the individual.

This concept is recognized in the conventional symbol of justice. You have seen her hundreds of times, a statuesque female figure with arm extended, holding in her hand a balance. Into one scale goes the crime, into the other, the punishment. When the two balance evenly then even-handed justice is done. And just so the lady won't be subjected to temptation, or be influenced by the wealth or poverty or other attributes of the individual affected, she is kept blindfolded. She is blind to the individual.

A new concept of justice has been rapidly gaining acceptance in recent decades. It is sometimes called "individualized justice."* It strips the blindfold from the lady. It not only permits her to see the individual, it bids her scrutinize him. It transfers much of the emphasis from *what* has he done to *why* has he done it; from what should we do *to* him to what should we do *for* him (See People v. Lewis, 260 N. Y. 171, p. 176).

The very first court to write into its statute this new concept was the juvenile court. It broke away from the traditional idea of administering even-handed justice. The quintessence of its modern philosophy is expressed in another scriptural quotation, somewhat more modern than the Mosaic law previously quoted. Matthew XVIII, 12-13:

> "How think ye? If a man have a hundred sheep and one of them be gone astray, doth he not leave the ninety and nine and goeth into the mountains and seeketh that which is gone astray? And if so be that he find it, verily I say unto you, he rejoiceth more over that sheep than over the ninety and nine which went not astray."

Thus the juvenile court was not designed to be and has never become a court as the man in the street thinks of a court, to wit, an agency for the administration of justice.

Now, how about the juristic conception of a court? Here is a simple dictionary definition: "A tribunal for the judicial investigation and determination of controversies;" or, more simply still: "A place where issues of law and fact are decided and the law applied to the facts found."

I have visited most of the major juvenile courts from Maine to California, from Texas to British Columbia. In studying their operations it was very seldom indeed that I ran across anything that even remotely resembled a court by either of the above definitions. (Of course I am speaking only of the juvenile court in its exercise of jurisdiction over delinquency.)

The "investigations" are not judicial. They are social. They do not emphasize the details of the offense or offenses committed. They do emphasize the child's biological and environmental background and constitute a social history of his life to date. They are not made in court, but in the field. They are not made by a judge, not even by a lawyer, but by a specially trained type of professional person called a probation officer or counsellor.† They are not legal, not "judicial." While they may invoke the ultimate exercise of judgment, they are not judgmental.

"Controversies" for judicial determination are rare. They arise for the most part when the child and his parents plead that he be "given another chance" and the judge is of the opinion some other disposition would be for the child's best interest. (Incidentally, the infrequency with which such controversies occur is a fair gauge of the efficacy of the preliminary casework on child and parents.)

"Issues of law" in the experience of all judges are rare. "Issues of fact" are almost equally rare and what is "applied to the facts found" does not resemble the law as we ordinarily conceive of it, although always within the law and authorized by law. For example, a statute reads: "Whoever commits burglary shall be imprisoned ten years." The issue of fact is, did he commit the burglary? If that is decided in the negative, the law is applied to the fact so found and he is set free. If decided in the affirmative, the law is applied to the fact so found and he is sent to prison for ten years. But when, in the juvenile court, a child is found delinquent, there is no fixed law to be applied to the fact found. On the contrary, the court is given exceedingly broad authority; it may do one or more of a number of things; it may even employ the trial and error method until it hits upon the right plan. (And considering the breadth of its authority, it is astonishing how ex-

*Roscoe Pound, Dean Emeritus of Harvard Law School, has written extensively on this subject. Two of his simpler and more recent essays are in the 1942 and 1944 Yearbooks of the National Probation Association.

†In a well-ordered community, investigations of the overt offenses are conducted by the police, school and other authorities rather than by any juvenile court officer.

traordinarily seldom any court is accused of abusing it.)

For these reasons it appears to me, at least, that the juvenile court is not a court according to juristic definition any more than according to the concept of the man in the street. Then what is it?

As I have said elsewhere,‡ the answer is best derived from an analogy. The court operates more like a hospital or a clinic than anything else. There are nearly thirty respects in which the analogy between the two appears valid. To mention a few:

If a person's bodily functions deviate so far from the normal that he cannot be properly treated in his home, he is ordered to a hospital. If a child's conduct deviates so far from the normal that it cannot be successfully corrected in the home, he is ordered to juvenile court.

The hospital gets the patient after he is sick. The court gets the child after he is delinquent. The hospital's function is to cure the patient and prevent him from becoming a chronic invalid; the court's, to correct the child and prevent him from becoming a chronic criminal.

The hospital's primary concern is the individual patient; it serves society, first by curing the patient and restoring him to society as an able-bodied citizen; second, by quarantining the occasional dangerous patient, through research, developing techniques, disseminating knowledge, preventive medicine, et cetera. The court's primary concern is the individual child; it serves society, first by reclaiming the future citizen; second, by quarantining the occasional dangerous child, through research, developing techniques, disseminating knowledge, leadership in preventing delinquency and crime, et cetera.

Generally speaking, the hospital doesn't have to find out whether the patient is sick, but why. Just so, the court doesn't have to find out whether the child is delinquent, but why. To digress a moment, this usually comes as something of a shock to laymen, lawyers, and most trial and appellate judges, and even to a new juvenile judge. What is either unknown or overlooked is the thoroughly established fact that children, unlike adults, almost always confess their offenses before they appear before the judge finally. In my own experience with over 12,000 delinquency cases, barely one in a thousand children has failed or refused to confess the offense charged. Even in the larger cities where some of the youngsters come from the heart of gangland and might be expected to have been schooled not to "talk," I am assured that confessions are received in ninety-nine out of 100 cases. This is the experience of juvenile court judges throughout the country. Usually the arresting officer has a confession before we meet the child. If not, the probation officer or psychologist, in the course of his efforts to win the child's confidence, is nearly always greeted with a confession, often covering offenses police or teacher or parent never dreamed of.

To resume the analogy, the patient describes his symptoms; the child discloses his delinquent acts, his symptoms. Just as a full description of symptoms by the patient facilitates accurate diagnosis, so the child's disclosure facilitates the court's diagnosis—and more. It is an indispensable prerequisite to successful treatment. Psychologically speaking, it fulfills the office of catharsis. Theologically speaking, it fulfills the office of confession, the basis of the sinner's forgiveness and redemption. Unless and until the child makes his confession, the court is powerless to help him more than superficially. It would be trying to help him build his future life on a foundation of falsehood, like building his house on sand, not rock.

After diagnosis, medical science prescribes the proper treatment for the patient; after diagnosis, the court does the same thing for the child. The hospital doesn't treat symptoms. It doesn't try to cure the fever patient by locking him in a refrigerator. No more does the court treat symptoms. It doesn't try to cure the truant by locking him in a schoolroom.

The hospital sometimes inflicts pain upon the patient, but to cure or protect—never to get even. If the court finds it necessary to hurt the child, it is always done for the purpose of disciplining or teaching him—never for the purpose of punishing or getting even with him. Juvenile courts do not punish. To punish means literally "to inflict pain." The words "pain," "punch," and "penalty" are derived from the same root as "punish."

To digress again, the four main reasons commonly advanced for punishing adults are (1) to deter, (2) to protect society, (3) to reform, (4) to avenge society. It has been proved time and again that as a deterrent punishment is no great success. Obviously there are cases where vicious and dangerous individuals must be quarantined for the

‡Yearbook, National Probation Association, 1941.

general security. As a reformative, punishment has been pretty much a failure, but the social and scientific facilities slowly but steadily being provided in our institutions lead one to expect continued improvement in this respect.

By all odds the most prevalent motive for punishing people is revenge—to get even with them. The individual has hurt society; therefore society hurts the individual; that evens the score. This "retributive justice" appears partly a hangover from the ancient *lex talionis*— the law of retaliation, an eye for an eye, a tooth for a tooth, et cetera. If you question the prevalence of this attitude, the next time a particularly heinous crime is committed in your community, read the editorials, talk to the man on the street and see what they think ought to be done to the guilty party. Instances can be cited by the dozen showing that the average citizen and even many of our supposedly enlightened citizens still think that the punishment should fit the crime. They want the offender to get "his due," get "what is coming to him," get "speedy justice." Most of them rationalize their primitive, punitive-vindictive impulses by extolling punishment as a deterrent, despite all the evidence to the contrary. Not so many speak of protecting society and almost none mention reformation.

Back to our analogy once more, the hospital does not employ amateurs, no matter how enthusiastic or well meaning, but professionally trained technicians. The same is true of the progressive court.

The successful hospital does not appoint its staff members with a view to their ability to get business or enhance the hospital's popularity. The modern court does not appoint its staff members with a view to their ability to get votes or enhance the judge's popularity (although a court that consistently disregarded public sentiment would soon come to grief both financially and politically).

A patient has a fever; the doctor uses a clinical thermometer, a microscope to examine the sputum, and takes an x-ray of the patient's lung. He diagnoses the case as tuberculosis. The patient's history shows he had a tubercular ancestor; that he has been living in squalor, ill-fed, ill-clothed, ill-housed. The doctor orders him to a sanatorium. There he gets cleanliness, a warm, comfortable bed, plenty of rest, nourishing diet. Eventually he is discharged and pronounced cured.

Who cured that patient? Was it the doctor with his thermometer, microscope, x-ray? Was it his placing the patient in a better environment? Was it the janitor at the sanitorium who kept the place clean? The nurse who kept him warm and comfortable and saw that he got his rest? The dietitian or cook who provided the nourishing food? Was it any one or all of these? Never yet have I found a doctor who had the temerity to suggest that medical science cured that patient. Doctors know better.

All the time that patient was lying in bed there was being formed around the diseased spot in his lung an enclosure of calcium, a stone wall. Eventually that stone wall literally imprisoned the tubercle bacilli and rendered them harmless. It was then that the patient was pronounced cured.

Who built that wall? The doctors have a name for it—*vis medicatrix naturae,* the healing power of nature. Call it God if you wish. That patient was cured by a supernal power, something above and beyond medical science or anything human. All that science could do was to remove the patient from the environment that was the source of his infection, place him in a wholesome environment, and give this higher power a chance to do its work. Doctors rely on it constantly. No doctor mends a broken bone. He simply brings the ends together so nature can do the mending. He removes obstacles in the way and sets the stage for this power; gives it a chance.

The same thing is true with the delinquent child. Reformation or rehabilitation or good conduct cannot be imposed upon him by force. You cannot *make* a child go straight. He has got to want to go straight. It has got to come from within. All that social science, psychological science, or the utmost skill in human endeavor can do is to remove as many obstacles as possible in the way of the operation of this supernal power so it can get in its work *within* the child; and through constancy of skilled, beneficent contact, subtly induce and help the child to change his attitude so as to give this power a chance.

Just to be realistic, I might cite one respect in which our analogy falls down. Most patients want to get well. Most delinquents do *not* want to go straight (which doesn't make the court's job any easier).

Now, if the juvenile court be so much more like a hospital or clinic than like the conventional conception of a court, if its application of the

principles of social science appear to be more in keeping with the practice of medical science than of legal science, then why bother to have a judge? Where, if any place, does the judge fit into the picture?

Let me make it perfectly clear that a legally trained judicial officer is an utterly indispensable part of the picture. In those rare instances where an issue of fact develops, there must be a judge to decide it, to determine whether the child did commit the offense. Who but a judge could decide the occasional issues of law, e.g., determine questions of jurisdiction of persons or of subject matter, questions of procedure, service, interpretation of statutes, et cetera; pass upon the validity of pleadings, entries, and other countless details of practice?

Always there is need of a judge to safeguard the constitutional guaranties of our federal and state bills of right; to make sure no child is deprived of life, liberty or property without due process of law; that no parent is deprived of the custody of his child without due process; that every child and necessary adult party has his day in court.

In case records as well as in hearings it takes a judge to detect and discount, or better, eliminate incompetent evidence, hearsay, rumor, suspicion, the testimony of incompetent witnesses; to guard against subjective as distinguished from objective attitudes on the part of officers and referees; to see that facts prevail over fancies; that science does not overstep the bounds of law or common sense in administering treatment.

There must be a judge to weigh such seeming imponderables as the child's best interests over against the natural and legal rights of the parent; as the child's best interests over against the general security or protection of society; a judge to act as arbiter when scientists can't agree; to serve as a check and balance upon the legalistic demands of the attorneys, on the one hand, and the idealistic demands of the theorists, on the other.

No court can be expected to rise above its judge. Therefore nothing transcends in importance the quality of the judge. He is both foundation and keystone of the court. The best of laws, the best of buildings, even the best of personnel will not make a good court if the judge is not qualified for his particular job. Conversely, a properly qualified judge can contrive a fairly good court despite various handicaps.

Now, as to what constitutes the proper qualifications of a juvenile court judge, I am going to be heretical again, and part company with those who write and speak on the subject. Of course, we've got to start with a good lawyer. That he should possess the highest degree of integrity, intelligence, industry, independence, patience, hard common sense, goes without saying. These are fundamental prerequisites of any judge in any court. But running a juvenile court is the job of a *specialist*. It demands special qualifications above and beyond those required of others.

Almost invariably, the first special qualification mentioned is "love of children." Here's my heresy: I think that is a mistake. It might even be dangerous. In our court, persons who prate of their love of children are suspect. The more loudly they protest, the more apt they are to be covering up some sort of rejection or personal inadequacy. Even if they keep quiet about their love for children, we have seen too many fond parents and others who love them not wisely but too well. One of the banes of our efforts to do constructive casework is the over-protective parent or relative or third person.

To revert again to our medical analogy, the best surgeon is not necessarily the one who loves his patients the most. The most skillful diagnostician or practitioner in any area of medical science is not necessarily the greatest humanitarian. The best executive or administrator is not necessarily one who is known for his love of humanity singly or in the mass.

I said that to make love of children the primary requisite might even be dangerous. It might lead to outright sentimentality. It might lead to handling the children's cases on an emotional basis. I have witnessed instances where that has occurred.

I hope no one will get the idea I am so foolish as to hold that love of children or of humanity or a humanitarian attitude is not a valuable asset. As I shall indicate a little later, no man who is not blessed with an exceptional degree of altruism should ever aspire to become or be permitted to become a juvenile court judge (for his own sake as well as the people's!). The point I am making is that something else should come first.

That first prerequisite of a juvenile court judge (beyond those standard qualifications required of all judges) should, in my opinion, be *eagerness to learn*. This is because he is entering upon a special field of activity for which he is not yet fitted. Observe I do not say unfitted. It is simply

that his previous education, training and experience were not calculated to fit him for this particular type of job. He certainly didn't learn anything of consequence about juvenile courts in college; I know of no law school that gives any courses in handling juvenile delinquents or in juvenile court philosophy; and chances are a hundred to one he never learned anything of consequence about the juvenile court in his law practice. The painful fact is that with exceedingly few exceptions every lawyer who ascends the juvenile court bench must go in green as grass.

A very great majority of juvenile court judges preside at the same time in other courts, which usually occupy much more of their time. For these other duties they have been specially prepared in law school, experienced in law practice. For example, the judge of a trial court must be expert in rules of evidence. He had opportunity to acquire the fundamentals through his schooling and practice. But obviously he has had no opportunity to become expert—which etymologically means "experienced"—in the juvenile court field. No more has he had opportunity to become a specialist in that field.

That the job is one requiring a high degree of specialization is steadily gaining recognition. This is because the work of the court is so much more social than legal, and ramifies into quite a number of fields of learning and disciplines and sciences such as the main social sciences, including social case work, group work, a little pedagogy, counselling, diagnosis and therapy, several branches of psychology, especially so-called abnormal psychology, penology, criminology, the basic principles of psychiatry, medical case work, community organization, child and family welfare and some others. Of course the judge is hardly expected to become an expert practitioner in any of these fields, but the degree to which he masters their fundamentals will determine the degree to which he can succeed in *eliminating the guesswork* in handling his cases. Verily he goeth into the mountains in seeking that which is gone astray!

Thus he can become truly fitted for his job only by a continuous intensive process of self-education; and even after years of this some of us are just coming to the point where we know how much we don't know.

Next to this *sine qua non* and as a corollary of it, I would place *genuine humility*. The judge must be a man who is willing to admit that even though he has had a successful law practice and is popular and energetic and clever enough to have won an election or an appointment, he still doesn't known all the answers; that his election or appointment has not suddenly endowed him with any new attributes or special knowledge. He must be willing to acknowledge that he needs guidance, advice, counsel, in this vast field so new to him.

Another prerequisite commonly overlooked or at least not stressed is that if he is to preside in a court of any size, he must be both a *good executive and a good administrator* (and many successful lawyers and judges of other courts do not qualify in this respect). This is because he is not solely a judge, but the head of an organization. As a matter of cold fact, in many cities he must spend more of his time discharging his administrative functions (largely outside regular hours) than his judicial functions, and the success of his court depends considerably upon his ability to organize, to select qualified personnel, to secure adequate finances, to frame sound policies and procedures and see that they are properly carried out.

A few years ago at the funeral of a judicial colleague of mine, the minister, in the course of his eulogy, had this to say:

> "Sometimes one is tempted to deride the legal profession when its members reach the honorable post of judgeship for having what is known as the 'judicial mind.' This mind, as I understand it, is neither hot nor cold; neither for or against, but like the church of Laodicea, is professionally lukewarm on all subjects that might spell progress. It is impartial, balanced, unenthusiastic, ponderous, chained by precedent."

If judges get that way—and I'm afraid plenty of us do—perhaps it is not solely because our whole system of jurisprudence is based upon the doctrine of *stare decisis*—to stand by the decisions. Maybe there is another reason. It seems to me the nature of our judicial work makes us peculiarly susceptible to the temptation to rely upon our individual experience—especially after we have been on the bench any length of time. I am hardly so foolish as to belittle the value of experience; the trouble is, too many of us have had too much experience doing things the wrong way.

A number of psychological studies have been made to measure scientifically the extent to which a person's effectiveness increases with experience. The findings indicate that it increases only up to a certain point. For example, in the teaching

profession, the teacher's effectiveness steadily increases up to about five years, after which it levels off and toward the end of a long career tends to diminish. If handling the child in court be anything like handling the child in the classroom, it would appear that the maximum of our judicial effectiveness was reached about five years after we mounted the bench, and has remained stationary ever since, and may be expected to diminish as we grow full of years and ripen with experience.

But these same studies have shown that the teachers who do not rely solely upon their original training and their experience, but who strive constantly to keep abreast of the latest developments in pedagogy, who attend summer schools and in-service training courses, who study professional periodicals and books, attend lectures—those teachers continue to increase in effectiveness almost without limit. Why shouldn't the same thing be true of us judges?

From the foregoing it would hardly appear that a juvenile judgeship offers an alluring prospect. First, the new judge is faced with the alternative of this strenuous self-educative regime or of muddling through and trying to gain experience as he goes along (with inevitable dire consequences to children and families).

Second, the position, with few exceptions, is seriously underpaid and hence not likely to attract the right kind of candidate (for that matter, this is true of most judicial positions). If he's able enough to make a good juvenile court judge, he's able enough to make a great deal more money in the law practice and make it with a fraction of the worry and effort.

Third, believe it or not, it is a much harder job than most ordinary judgeships. When confronted with a baffling problem of child behavior, the judge cannot repair to the law library, run down the indexes and pull out a case in point that will give him the solution. The judge does not have any jury to whom he may pass the buck of deciding difficult questions. His problems are often far more subtle and intangible and call for the exercise of broader comprehension, keener insight and more skillful ingenuity than legal questions. Intricate though the law be, human behavior is more intricate still.

Fourth, except perhaps in some smaller communities, the job involves a larger volume of work and requires the judge to put in many more hours in court or at his desk. In the larger cities the judge of the juvenile court commonly works in court, at his desk, and in essential extracurricular activities, two or three times as many hours as the judges of other courts. This is especially true where he presides over another court in addition to his juvenile work. Not only does he work longer hours; the volume of cases coupled with all the administrative details keep him working under unrelenting pressure. (While this may be bad for his blood pressure, it is worse for his clients who are entitled to an unhurried hearing before an unharried judge).

And fifth, the job carries with it a minimum of prestige. Lawyers and laymen alike shrug their shoulders and say: "You don't have to know any law to be a juvenile or family court judge." In many places it is regarded as a sort of necessary evil, appended to the trial or probate judgeship. (Witness the insistence of so many trial judges upon "rotating" the juvenile job—a device whereby each limits his servitude on the juvenile bench to six months or a year or two.) With few exceptions, his court is relegated to the most cramped, dingiest and least desirable quarters. Because he is one of the few judges with any considerable patronage at his disposal, he is beset by job-seekers and politicians; and for the same reason he has all the headaches that go with appointing a staff, adjusting salaries, making replacements, keeping it happy and functioning smoothly; and he has the highly important and equally unpleasant task of battling for sufficient budgets, considered by most judges their worst single headache.

Yet despite all these drawbacks, the court that handles children's and family problems is in many respects the most important of all the courts. While it is less spectacular in that it does not transfer large sums of money from one person's pocket to another's, or handle sensational criminal trials, nevertheless, in the number of individuals affected and in the effect upon the sum total of human happiness and the welfare of future citizens of the state, it far surpasses the ordinary civil or criminal court in importance.

Obviously, it is a job that has got to be done, and it has got to be done right; and it can be done right only by a judge who is willing to train himself to do it right. After all, none of the boys who flew B-29s over Europe or Asia wanted to do that job. But they knew it was a job that had to be

done and had to be done right; and that they had to fit themselves to do it right.

So, in addition to emphasizing that the job requires a man who is eager to learn, we may as well be frank about it and emphasize that no man should become a juvenile judge unless he is able and willing to make serious financial and personal sacrifices. In other words, he must be blessed (or cursed, depending upon the point of view) with an unusually high degree of altruism. And since, no matter how brilliant or industrious he may be, it will take him so many years to become anything resembling an expert, he should be in position to sacrifice all other ambitions and make this his life career. Above all he must never consider using his juvenile judgeship as a mere stepping-stone to some more lucrative and less difficult judicial position!

Now just in case you are beginning to wonder if all this elaboration on the need for a "specialist" judge is just some social worker's dream or just starry-eyed idealism, let me quote from the most hard-boiled and realistic source I know of, a newspaper editor. Here is what is said by F. Perry Olds, of the *Milwaukee Journal*:

"The personality of even a small child is far more complicated in its details than the most complicated contract, the most involved dispute at law or the most controverted question in ethics. Men who are learned in law are rarely trained in the niceties of human relations. They are not necessarily gifted, either, with social foresight, which they would have to be to proceed successfully in these delicate matters without previous training.

"As time goes on, then, and we begin really to appreciate the power of the juvenile judge for good or ill, we will want to dissociate the juvenile court from the courts of law. We will want to set up a separate tribunal, devoted to solving problems in human relations. . . .

". . . We will want to have candidates for judge of that court to run as such. . . .

". . . The foundation of the whole structure . . . must be an adequate juvenile court—equipped to diagnose and to prescribe treatment presided over by a 'specialist' judge, who joins training and understanding."

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The Council on Medical Education and Hospitals of the American Medical Association approved 6,280 hospitals containing 1,468,714 beds and 84,145 bassinets during 1947. Approximately 15,153,452 patients were admitted to these hospitals during 1946.

Improved Legal Procedure for the Care of the Mentally Ill

By Judge Arthur E. Moore
Pontiac, Michigan

A woman needed shock treatment for mental illness short of insanity. Neither the writer nor the head of the state hospital could convince her family of the need. Not being insane she could not be hospitalized and treated against her will. Three days later she murdered a man.

This true story, with variations, is repeatedly being re-enacted. Confusion and misunderstanding between doctors and lawyers, together with public apathy block progress in mental hospitalization and care.

Doctors, concentrating upon prevention and cure of mental illness are apt to be irritated by the legal requirements concerning involuntary cure and treatment. Believing sincerely that the enforced hospitalization is so obviously for the welfare of the patient, the physician may feel that the law requiring judicial proceedings for determination of insanity as a prerequisite to mandatory care and treatment, is unnecessary legal technicality and red tape.

On the other hand, the lawyer clings to his old concepts of insanity and refuses to think in any other terms.

All professional people are likely to be somewhat dictatorial concerning the treatment or procedure which they believe to be common professional practice.

So the lawyer insists no person may be deprived of personal liberties without due process, and the physician insists that preventive medicine should be practiced even against the patient's will.

There is great truth in both assertions. The unfortunate thing is that we have not tried very hard to comprehend each other's viewpoints.

Then there is the third point of view, that of Mr. Ordinary Public, and at times he disagrees with both the legal and medical viewpoint and again he vehemently sides with one or the other.

Read at the "Child Guidance Meeting" of the Michigan Society of Neurology and Psychiatry, February 20, 1947, Detroit, Michigan.

Judge Moore is Judge of Probate Court for the County of Oakland, Pontiac, Michigan; chairman, Legislative Committee and Secretary, Michigan Probate Judges Association.

For instance, if he firmly believes in psychiatry and is not the patient, he takes the medical viewpoint, but if he is the patient or thinks mental hospitals are still asylums for crazy people, he will side with the legal viewpoint.

Thus we lawyers and you doctors have a joint obligation to improve the whole medical-legal concept and procedure. The first step is toward better mutual understanding and then the second is toward education of the public.

Unfortunately the very fact that the patient must appear in a court proceeding often disturbs and aggravates his mental condition. Thus the very act of protecting the patient's personal rights serves to aggravate his mental disturbance. This makes it more difficult for the medical staff and hospital to secure his co-operation and confidence in the care afforded him. So, in many cases the present procedure for the commitment of insane persons to state hospitals, through the existing legal machinery of the probate court, is in itself a deterrent or blockage against recovery and defeats to some degree the very purpose of the proceedings.

It should be remembered that the present law (M. S. A. 14.801 et. seq.) now provides for voluntary hospitalization. However, voluntary hospitalization is unworkable because the law does not permit the medical superintendent to accept any patient for treatment who is mentally incompetent (M. S. A. 14.809), and also because a voluntary patient who is mentally ill usually changes his mind and leaves the hospital before treatment has been completed.

It has been suggested by some students of the problem that insane persons should be confined in the state hospitals merely on the certification of a doctor or health officer, that the patient needs care. Such a bill was introduced in the 1947 session of the Michigan Legislature (House Bill 500). Unfortunately it did not provide an opportunity for a judicial hearing and was clearly unconstitutional. It provided that once a patient was safely confined in the hospital, the medical superintendent should be required to ask him whether or not he desired a hearing. If he replied in the affirmative, a probate court hearing was then to be afforded. This proposal was unconstitutional, for the very fact of enforced confinement under the medical superintendent negatives freedom from coercion. Then too, one who is insane cannot waive his rights nor consent to any proceeding (North v. Joslin, 59 Mich. 624).

The law appears to be clear that we may arrest a dangerous insane person without court process (10 A. L. R. 488), but such procedure cannot be expected to operate smoothly because, without court process, the arresting or incarcerating agent must assume responsibility as a guarantor for the factual proof of such dangerous insanity (Crawford v. Brown, 97 N. J. Eq. 92, 116 Atl. 796, 45 A. L. R. 1464). The health officer cannot be positive that the patient's apparent condition is not caused by drugs, liquor, epilepsy, or physical disease other than the less tangible chemical or physiopathological changes associated with insanity. Case histories of attempted homicide, hallucination or persecution complex may be misleading and are usually hearsay and dependent upon the credibility of the informants. Then too, psychiatrists often disagree. The result is that both the committing health officer and the hospital superintendent being legally accountable for unmerited confinement of the patient, as false arrest and imprisonment, will refuse to act until they are afforded the protection of court process.

Thus, we must find a way to avoid the trauma and stigma of court procedure and still afford legal protection to both the patient and the hospital through court procedure. I contend we may accomplish these seemingly incompatible objectives in the following manner:

1. Discard the staid legal definitions of insanity and substitute medical definitions of those mentally ill.
2. Emphasize prevention and cure.
3. Improve hospital research and care.
4. Encourage a more wholesome community attitude toward patients who need mental care.
5. Encourage public reliance upon our courts as protective agencies.
6. Send patients to hospitals for prevention and cure of potential illness instead of insanity.
7. Provide brief hospitalization for examination and diagnosis to determine more accurately the patient's needs.
8. Permit the patient to retain his civil competency rights in all cases except where in the court's discretion temporary suspension thereof is necessary for the patient's protection.
9. Reserve full rights to hearing on the need of compulsory care and treatment at *any* stage of the hospitalization and thus reduce the trauma and apprehension of the patient by affording him protective security by right to court review.
10. Provide more kindly court process and procedure.

Insanity is a legal term. It was never designed to define mental illness as a medical term. The term *insanity* is the lawyer's definition of that degree of mental abnormality which excuses the person for his criminal acts or relieves him from responsibility for his contracts or negligence, or vitiates his will.

There must be a point where a man is excused for his crime, or not obligated upon his contract or deed of conveyance, or where he is without sufficient mentality to make a will or manage his own affairs. So insanity is a legal term involving mental competency and responsibility. Mental illness merely defines his health.

Thus if a man has delusions unrelated to his property transactions his contracts may be valid and enforced (Nebus v. Wein, 301 Mich. 293).

Our courts have held that though a person may have many mental peculiarities, yet he is competent to deed property if he has sufficient mental capacity to understand the business in which he is engaged, the extent and value of his property and how he wants to dispose of it and to keep those facts in mind long enough to plan and effect those conveyances without interference or prompting from anyone (Terry v. Terry, 170 Mich. 330).

To excuse criminal culpability the insanity must be to such a degree that the respondent was incapable of forming an intent to commit the act (People v. Sharac, 209 Mich. 249).

Less mental capacity is required to make a will than to make a contract or deed (Estate of Lembrich, 243 Mich. 39), and mental incompetency for guardianship does not require that one be a lunatic (Beattie v. Bower, 290 Mich. 517).

I know a man suffering from paranoia who has hallucinations of persecution. He falsely believes that his wife and child have repeatedly attempted to poison him. Yet living apart from them he has been a good citizen and has worked steadily at the same valuable employment for thirty years. Is he insane? No jury will force him into confinement—at least until he attempts to injure someone.

Certainly his contracts are enforceable, and his will is probably valid unless it is prejudicial to his wife and child. Certainly he does not merit guardianship. If he kills anyone other than his wife or child he will probably pay the criminal penalty, but if they become his victims, he will then be excused as insane.

Now in spite of the niceties of these legal aspects of insanity, this man is mentally ill, and needs care and treatment, particularly since the paranoia may be progressive.

So the lawyers and doctors have been living apart in their concept of this mutually challenging problem. We need mutually acceptable objectives. The lawyers' definition of insanity is irrelevant—beside the point. The doctors' definition of mental illness is too broad.

We need a new definition for the type of mental illness which justifies enforced care. To state the problem another way, how may we extend enforced medical care to an unwilling patient and still not infringe upon his personal sanctity?

Our problem is clearer when we remember that Christian Scientists do not believe in medicine; that some religious groups resist immunization; that the hospital scheme of refusing the reluctant or insolvent patient his clothes is at best a spurious way of meeting a real issue.

Constitutionally, we can accept and substitute the medical definition of one suffering from mental illness as,

> "The person who now is or with reasonable probability or certainty soon will become mentally ill to a degree which will so lessen the capacity of such person to use his customary self-control, judgment and discretion in the conduct of his affairs and social relations as to make it advisable for him to be under medical and hospital treatment, care, supervision or control,"

if we limit the enforced care of such persons to cases where it is (1) for their own welfare, or (2) for the protection of society.

Thus the fundamental law is available for hospitalization of the mentally ill—if we lawyers and doctors will only get together, have mutual understanding and interpret our joint objectives to the public.

Are we too busy? Or shall we find time to reorganize our concept of the problem and revise the statutes concerning enforced care of the mentally ill?

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The average American, according to the Bureau of Medical Economic Research of the American Medical Association, spends $3 more per year on cosmetics and personal care than for the services of physicians.

Use of Thiouracil in the Treatment of Angina Pectoris

Report of Sixteen Cases

By Ralph Lee Fisher, A.B., M.D., F.A.C.P., and Morris Zukerman, A.B., M.D.

Detroit, Michigan

R. L. Fisher

The treatment of angina pectoris by attacking the thyroid gland is not new. In 1933, Blumgart, Levine and Berlin[12] advised the removal of the entire thyroid gland for the control of severe angina pectoris. Total thyroidectomy attempted to relieve angina pectoris, first, by interrupting some of the cardiac nerve connections; second, by reducing the metabolic rate, and lastly, by enforcing a long period of rest on the patient before recovery from surgery took place.

In some of the cases the results were not satisfactory, especially when the degree of coronary artery disease was marked or when myxedematous signs and symptoms were hard to control by the use of thyroid extract without inducing angina pectoris. Blumgart[12] analyzed the results of total thyroidectomy for angina pectoris in ninety-five cases with the following results: excellent results were obtained in forty-five cases (47 per cent); twenty-nine cases (31 per cent) were moderately improved; eleven cases (12 per cent) were slightly improved, and ten cases (11 per cent) showed no improvement. Total thyroidectomy as a treatment for angina pectoris has for the most part been given up. It is a serious operation and the results have not been sufficiently favorable to justify such a difficult operation and the establishment of myxedema.

Eppinger and Levine[6] felt that complete removal of the thyroid gland reduced anginal pain by altering the response of the cardiovascular system to epinephrine. The role of epinephrine in angina pectoris has been demonstrated through the various experimental and clinical data submitted by many authors. Cannon[4] demonstrated that there was a physiological discharge of epinephrine into the blood stream during exercise, exposure to cold, and during emotional responses. These factors have all been known clinically to produce angina pectoris.

Levine, Ernstene, and Jacobson[8] produced the pain of angina pectoris in patients with coronary sclerosis by the injection of epinephrine. Rabb[10] has shown that patients who have suffered from the symptoms of angina pectoris have abnormally high concentrations of epinephrine in their heart muscles. Brunschwig, Humphreys, and Roome[3] have shown that some patients with adrenal medullary tumors have anginal symptoms. Lenhartz[7] has shown that the symptoms of angina pectoris have disappeared after the removal of the tumor. Rabb and Soule[11] have used roentgen irradiation over the adrenal gland to prevent the discharge of epinephrine into the blood stream of the patient with angina pectoris. This has frequently caused the disappearance of anginal symptoms in these patients.

Rabb[9] feels that the anginal syndrome is produced by the accumulation of an acute excess of epinephrine and sympathin in the heart muscle. As a result there is a local anoxia produced in the heart muscle whose coronary arteries are hard and sclerotic and which has become sensitized to epinephrine through the action of the thyroid hormone.

Rabb[9] has shown also that the sensitivity of the heart in rats to epinephrine has been reduced after the treatment with thiouracil. This experiment was reproduced later in ten healthy persons after three months of thiouracil administration. It is felt that thiouracil acts by depressing the anterior pituitary so that the thyroid stimulating hormone is lowered. It also acts on the thyroid gland directly by inhibiting the ionization of the thyroglobulin molecule and, therefore, the production of an active thyroid hormone. With these facts in mind, it was suggested that the administration of thiouracil would act as a substitute for thyroidectomy, with the additional advantage of not subjecting the patient to any surgical risks. Rabb[9] administered this drug to ten patients with angina pectoris. The treatment was effective in seven out of ten, and four patients became entirely free of symptoms during the time they were treated.

Ben-Asher[2] has reported the treatment of eight patients with angina pectoris by the use of thioura-

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cil. Excellent results were noted in two cases, good in five cases, and fair in one case.

In order to assay accurately any damage or influence that thiouracil might exert on organs other than the thyroid itself, rather extensive renal, liver, and metabolic tests were later run on many of these patients.

The following case reports are illustrative of the type of patient and results obtained with this form of therapy.

Case Reports

Patient No. 2.—Mrs. W. W., a well-developed, well-nourished white woman was seen for the first time on March 23, 1940, at the age of forty-two. In the past four years she had been treated for marked hypertension. Two weeks before coming to the Outpatient Department she had experienced an aching sensation in both cubital fossae followed promptly by a heaviness and pressure beneath the upper sternum. This attack of pain was relieved by medication administered by her doctor.

Physical examination revealed a chronically ill woman whose temperature and respirations were normal. Her pulse was 104 and her blood pressure was 258/148. The left border of her heart was at the anterior axillary line; there was a heaving apical impulse and a soft systolic murmur at the apex which was not definitely transmitted. Routine laboratory work revealed a normal hemoglobin determination, white blood cell, red blood cell and differential counts. The Kahn and Kline tests were negative. Urinalysis revealed a one plus albumin. The blood urea was 21.8 mg. per cent.

A chest x-ray revealed a cardiac enlargement involving chiefly the left ventricle. An electrocardiogram was interpreted as showing left ventricular preponderance. The patient was put on digitalis to correct cardiac decompensation and was also given sedation, aminophyllin, and nitroglycerine as needed for chest pain. The patient readily became compensated but began to note a progressive increase of her attacks of substernal pain which radiated down both arms. Her anginal pains were marked, especially at menstrual periods.

The patient made regular visits to the Outpatient Department. However, her anginal attacks became more noticeable, lasted longer, and required two to three nitroglycerine tablets to give relief. On February 19, 1943, she was having severe anginal attacks almost every hour, which were precipitated by emotion and the slightest exertion. By November, 1943, she was unable to make office visits because of unbearable chest pain on exertion. On August 9, 1945, she was started on thiouracil, 3 grains (0.2 gm.), after meals, and told to continue with her nitroglycerine as needed. Four days later she volunteered the information that her condition was unchanged. Nine days after thiouracil was started she reported that she felt much better; that she was still having frequent attacks of anginal pain, but that each attack was easily terminated by the use of one nitroglycerine tablet, whereas formerly her attacks of angina caused excruciating pain lasting two to three minutes, and which were difficult to relieve with as many as three nitroglycerine tablets.

She was seen in the Outpatient Department on August 22, 1945, at which time she stated that she felt better. Two days later she informed us that she was having chest distress every hour but that this was easily terminated with nitroglycerine. One week later and the week following, she informed us again that she had frequent chest pain but that the attacks were not severe. On September 7, 1945, she reported that she had been free of chest pain for three consecutive days. Two weeks later she complained of frequent chest pains. From October 11 to October 23, 1945, she had less chest distress and stated she felt well for the first time since her treatment had started. On November 23 and December 4, 1945, she told us that she was having only one or two attacks of chest distress per day which were not so severe and were easily relieved by nitroglycerine. She was seen at ten-day intervals and told us that her chest pain was negligible.

On January 24, 1946, her thiouracil was reduced to 1½ grains (0.1 gm.) after meals and at bedtime, since she had a white blood cell count of 4,050 and a red blood cell count of 3,630,000. Three weeks later she noticed severe attacks of chest pain after being notified of her son's death while in the armed services. On February 23, 1946, she again felt well and was not having severe chest pain. On March 9, 1946, her white blood count was 6,400 and her blood pressure was 270/138. She was feeling well. The following month her thiouracil was increased to three grains (0.2 gm.) after meals. She continued to report that she felt well. She was seen at two-week intervals and continuously informed us that she had only an occasional attack of angina, which was readily relieved by nitroglycerine. While on thiouracil therapy she was able to make routine office visits, which she had been unable to do since November, 1943, because of the severe pain associated with exertion necessary to come to the office.

On May 13, 1946, the patient was seen at home when she stated that she had had some slight chest pain previous to her menstrual period. A week later she was seen again, at which time she informed us that she was not having any chest pain or palpitation on exertion. She continued to make routine office visits. On July 12, 1946, she was seen at home since she complained of marked fatigue and felt that she could not keep her office appointment. She did not have any chest distress, shortness of breath or palpitation. Examination revealed moderate puffiness of the face and hands. The thyroid gland was moderately enlarged and soft. Her heart rate was 76 and the rhythm was regular. The dosage of thiouracil was reduced to overcome the symptoms of myxedema.

The patient was seen at two-week intervals and was maintained on thiouracil, grains 1½ (0.1 gm.) twice a day. She continued to feel well until August 31, 1946, when she began to complain of having a recurrence of severe chest pain on the slightest exertion. Careful questioning revealed that she had discontinued thiouracil voluntarily in an attempt to overcome the

fatigue associated with a moderate degree of myxedema which had been difficult to control.

She was immediately put back on thiouracil, grains 3 (0.2 gm.) after meals, and a marked clinical improvement was noted in approximately one week. She has been seen at two-week intervals. Blood counts were done at each visit in order to detect any tendency toward developing hematological complications.

The dosage of her drug has been continuously changed in order to overcome the resulting myxedema. This patient has found that without thiouracil her chest pain is unbearable and that the ordinary medical measures will not give her relief of her angina pectoris.

Patient No. 3.—The patient, Mrs. R. B., was an obese white woman, aged fifty-nine, who was first seen in the Outpatient Department on April 19, 1944. At that time she had complained of substernal distress, noted on exertion, which was relieved by resting, or the use of nitroglycerine tablets. She was seen at infrequent intervals and attempts were made to relieve her chest distress by all conservative means available. She responded poorly to treatment.

On October 27, 1945, the patient entered the hospital complaining of substernal pain and nausea and vomiting of three days' duration. She appeared to be a very acutely ill woman whose skin was cold and clammy and whose blood pressure was 150/100. Physical examination revealed that the left border of her heart was at the anterior axillary line and there was a heaving apical impulse. No murmurs could be heard and the rhythm was regular. Laboratory data revealed a hemoglobin determination, red blood cell, white blood cell and differential counts to be within normal limits. The sedimentation rate was markedly increased. The Kahn and Kline tests were negative, as was the urinalysis. The chest x-ray revealed a marked cardiac enlargement. The electrocardiogram showed an acute posterior wall infarct.

The patient's course in the hospital was uneventful except for a bilateral pleurisy. She was discharged two months later, having been given luminal, ½ grain (0.03 gm.) before meals for sedation, and nitroglycerine, 1/100 grain as necessary for chest pain. For approximately two months after her discharge from the hospital the patient complained of severe substernal distress, noted only on exertion, which left her weak and nauseated. On February 9, 1946, the basal metabolism test was read as plus 6 per cent. Her blood pressure was 166/106. She was started on thiouracil, 3 grains (0.2 gm.) after meals. Seven days after this theapy was initiated she had only an occasional attack of substernal pain.

Four days later the patient reported to us that she had been free of any chest pain for the past four days. Five days later a basal metabolism test was read as plus 3 per cent. She had had only two slight attacks of substernal pain since her last visit which were easily relieved by a tablet of nitroglycerine. On March 1, 1946, she was again seen in the Outpatient Department at which time she stated that she had had three mild attacks of chest pain since her last visit. Six days later she stated that she was free of chest pain, and the thiouracil was reduced to 1½ grains (0.1 gm.) after meals. The patient continued to feel well until March 19, 1946, when she had severe substernal pain radiating down the left arm which lasted for about forty minutes. After being admitted to the hospital, serial electrocardiograms revealed a recent posterior wall infarct.

While in the hospital, the patient was put on sedation and digitalis since she had broken compensation. She observed that, while turning in bed, she would have severe substernal pain which would radiate down the left arm and which was relieved with difficulty by the use of one to three tablets of nitroglycerine. On April 2, 1946, she was started on thiouracil, 1½ grains (0.1 gm.) twice a day. The following day she had one slight attack of anginal pain which was easily relieved by a tablet of nitroglycerine. Four days later she had two severe attacks of angina which left her short of breath.

The patient was discharged from the hospital on April 7, 1946, and her thiouracil was increased to 3 grains (0.2 gm.) after meals. Five days after her discharge from the hospital she stated that she had had only two slight attacks of angina on exertion and that nitroglycerine was not necessary to relieve the distress. Six days later she was feeling well until she began to experience profuse, steady vomiting of undetermined origin which precipitated mild anginal pain. On April 26, 1946, she stated that she was feeling well and was up and about without any chest distress. She was seen again at ten-day intervals from May 3 to July 8, 1946. On the former date the thiouracil was reduced to 1½ grains (0.1 gm.) after meals and at bedtime.

On July 29, 1946, the patient began to complain of puffiness of the eyes and swelling of the neck anteriorly. As a consequence her thiouracil was reduced to one and one-half grains (0.1 gm.) after meals. On August 12, 1946, the thiouracil was discontinued because of accentuation of the above symptoms. Ten days later we received an urgent call from the patient stating that her anginal pain had returned and was of such nature that she was unable to exert herself without excruciating substernal pain. She was then put on thiouracil, grains 3 (0.2 gm.) after meals. Three days later she still complained of severe anginal pain on exertion.

On September 3, 1946, the patient still complained of many attacks of chest pain on exertion. A basal metabolism test was read as a minus 8 per cent. The patient was then seen at weekly intervals. She noted gradual improvement in her chest pain until September 23, 1946, when she stated she was free of any pain on exertion.

A week later she again began to complain of puffiness of the eyes, and her thiouracil was reduced to grains 1½ (0.1 gm.) after meals and at bedtime. In an effort to reduce the myxedematous symptoms, she was given thyroid extract, ¼ (0.015 gm.) grains after meals, in conjunction with thiouracil therapy from September 30 to November 11, 1946. On October 14, 1946, a basal metabolism test was read as a minus 5 per cent. The following week the patient began to complain of chest pain again, and as a consequence the dose of thiouracil was doubled.

On November 11, 1946, a bromsulfalein test did not reveal any dye retained at the end of thirty minutes. A basal metabolism test was read as plus 13 per cent. On November 21, 1946, the phenolsulphonphthalein test revealed 35 per cent of the dye excreted in one hour. The nonprotein nitrogen was 34.2 mg. per cent (normal 25-35 mg. per cent); the blood urea was 67.4 mg. per cent (normal 20-40 mg.) and the blood cholesterol was 387.5 mg. per cent. On this latter date the prothrombin time was 80 per cent of normal; the hippuric acid test revealed that 0.96 grams were excreted.

On November 22, 1946, the basal metabolism test was read as minus 7 per cent; the clotting time was four minutes; the bleeding time 2.5 minutes, and the platelet count was 464,000. On November 23, 1946, the cephalin flocculation test was negative in twenty hours; acid phosphatase revealed 2 King-Armstrong units and the alkaline phosphatase 3 King-Armstrong units. The inorganic phosphorous revealed 4 mg. per 100 milliliters of serum, and the calcium was 10.2 mg. per 100 milliliters of serum. The total proteins revealed 7.6 grams per 100 milliliters of serum, with the albumin being 4.6 grams and the globulin 3 grams per 100 milliliters of serum.

The patient was continued on thiouracil until November 29, 1946, when she was started on propyl-thiouracil. At each office visit a complete blood count and urinalysis was done. However, after three weeks had elapsed she was so uncomfortable that it was necessary to reinstate plain thiouracil therapy again.

Patient No. 5.—The patient, Mr. R. A., was first seen in December, 1944, at which time he noticed a choking sensation while working. In addition, he noted a severe crushing sensation located substernally which radiated laterally to the right and over his precordium. This pressure sensation was noticed on the slightest exertion and had occasionally radiated to the right cervical area. The substernal oppression was relieved immediately by resting or by the use of nitroglycerine.

Physical examination revealed an obese white male whose temperature, pulse and respirations were normal. His heart was not enlarged on percussion, no murmurs were heard, and the rhythm was regular. Laboratory data revealed a normal hemoglobin determination, differential, white blood and red blood cell counts. The urinalysis was also within normal limits. The Kahn and Kline tests were negative. The electrocardiogram was interpreted as left axis deviation.

The patient was put on sedation, aminophyllin 3 grains (0.2 gm.) after meals and at bedtime, and nitroglycerine under the tongue as needed to relieve chest pain. On this regime he did not improve, his attacks came frequently on the slightest exertion, and he was unable to carry on with his work. The patient was seen at frequent intervals in the Outpatient Department during the interim. On April 20, 1946, he was told to discontinue all former medications and was placed on thiouracil, 3 grains (0.2 gm.) after meals and advised to use nitroglycerine as needed. Five days after treatment was started, he felt improved, stating that he could go for rather long walks without any chest pain. Two weeks after therapy was started he reported to us that he was able to walk as long as he wished without chest pain and that for the first time he was able to do light work without any chest distress. On May 11, 1946, he informed us that he was now able to walk and to work freely without any fear of pain for the first time since his illness began one and one-half years ago. His thiouracil was reduced to 1½ grains (0.1 gm.) after meals and at bedtime.

He was seen on May 18 and June 11, 1946, at which times he had been entirely free of pain. Eleven days later he noted two episodes of chest pain for the first time since being placed on thiouracil therapy. His thiouracil was then increased to 3 grains (0.2 gm.) after meals. On June 29, 1946, he had had one episode of chest pain after walking for two blocks. One week later he notified us that he was feeling well.

The patient was continued on thiouracil, grains 1½ (0.1 gm.) twice a day, until July 20 when the frequency of the dose was increased to four times daily. The patient was seen at two-week intervals and continued to feel well and did not experience any chest pain after exertion. On October 5, 1946, his basal metabolism test showed a plus 8 per cent. Two weeks later the patient volunteered that he had a pressure sensation substernally if he exerted himself too strenuously. On November 16, 1946, physical examination revealed that his neck was enlarged anteriorly and his thyroid gland was moderately enlarged and soft in consistency.

On December 2, 1946, the value for nonprotein nitrogen was 31.5 mg. per cent; the blood urea was 17.1 mg. per cent, and the blood cholesterol was 222.2 mg. per cent. The prothrombin time was 100 per cent of normal; 48 per cent of the dye was excreted in one hour on the phenolsulphonphthalein test; the bromsulfalein test did not reveal any dye retained in one-half hour. The hippuric acid test revealed that 0.72 grams of hippuric acid were excreted.

On the following day, the basal metabolism test was read at plus 3 per cent; the clotting time was four minutes, the bleeding time was 2.5 minutes, and the platelets numbered 250,100. On December 5, 1946, the cephalin flocculation test was negative in forty-eight hours and the inorganic phosphorus was 2.6 mg. per 100 milliliters of serum. The calcium determination revealed 10.2 mg. per 100 milliliters of serum; the alkaline phosphatase was 5 King-Armstrong units, and the acid phosphatase was 3.5 King-Armstrong units.

The albumin revealed a total of 6.72 grams per 100 milliliters of serum with the albumin being 4.75 grams per 100 milliliters of serum and the globulin being 1.97 grams per 100 milliliters of serum.

On December 14, 1946, the patient was started on propyl-thiouracil. A complete blood count and urinalysis were performed on each visit to the Outpatient Department.

Patient No. 14.—The patient, Mr. M. C., was first seen on March 15, 1946, at which time he stated that he was having chest pain after eating and following exertion. He had had this condition for three years. The pain was retrosternal and radiated down his left

arm. The patient was unable to walk for more than a block without noting the chest distress. The pain would cease immediately upon cessation of all activities, and nitroglycerine under the tongue relieved the severe, vice-like substernal distress.

Physical examination revealed an obese, white, seventy-five-year-old male who was not acutely ill. His temperature, pulse and respirations were normal. His blood pressure was 165/80. The lungs revealed an occasional râle at the right base. The heart was within normal limits to percussion. The rhythm was regular, and there was a soft, blowing systolic murmur heard at the aortic area. Laboratory data revealed the hemoglobin determination, white blood cell, red blood cell and differential counts to be within normal limits. The urinalysis and the Kahn and Kline tests were within normal limits. A chest x-ray was normal for a man of his age. The electrocardiogram was normal.

On the day of the first examination the patient was started on thiouracil, 3 grains (0.2 gm.) after meals, and he was advised to take nitroglycerine as necessary to relieve his chest distress. Three weeks later a basal metabolism test was read as minus 1 per cent. The patient complained of soreness in his chest but no frank anginal pain on exertion. His thiouracil was then reduced to 1½ grains (0.1 gm.) after meals and at bedtime. One week later the patient declared that he was feeling well and was not having soreness in his chest on exertion. On April 23 and April 30, 1946, he informed us that he was feeling fine and did not have any chest pain. A basal metabolism test on the latter date was recorded as plus 1 per cent. One week later he stated that he had one slight episode of chest pain after mowing his lawn. Two weeks later he told us that he had had one slight episode of chest pain precipitated by walking too fast. On the following visit he informed us again that he was feeling fine and had only an occasional bout of chest pain after a heavy meal.

On June 18 and July 6, 1946, he informed us that he was feeling well and not having any chest pain. On July 17, 1946, he remarked that he felt fine and had only occasional slight chest distress after eating a hearty meal or walking too fast.

The patient was seen at two-week intervals and stated that in spite of all his activity, he did not have any chest pain. On September 6, 1946, a basal metabolism test was read as minus 11 per cent.

On November 26, 1946, laboratory data revealed the following: nonprotein nitrogen was 40 mg. per cent; the blood urea was 33.1 mg. per cent; the blood cholesterol was 222.2 mg. per cent; the prothrombin time 100 per cent of normal. The hippuric acid test revealed 0.83 grams of hippuric acid to have been excreted; the phenolsulphonthalein test revealed 40 per cent of the dye to have been excreted; the cephalin flocculation test was negative in twenty-four hours, and the bromsulfalein test did not reveal any dye retained in one-half hour.

On December 2, 1946, the basal metabolism test was a minus 26 per cent; the clotting time was 3.5 minutes; the bleeding time was 4.5 minutes, and the platelet count revealed 529,000 platelets. On December 5, 1946, laboratory data revealed an inorganic phosphorus of 3 mg. per milliliters of blood; the calcium was 9.75 mg. per 100 milliliters of serum; the alkaline phosphatase was 4.5 King-Armstrong units; the acid phosphatase was 1.7 King Armstrong units; and the blood proteins were 7.05 mg. per 100 milliliters of serum, with the albumin being 5.03 mg. and the globulin 2.02 mg.

On December 6, 1946, physical examination did not reveal any enlargement of the thyroid gland, swelling of the face or unusual dryness of the skin. On this latter date, the patient informed us that he was able to dance without chest distress. A complete blood count and urinalysis were done at the time of each visit to the clinic. On December 16, 1946, the patient was started on propyl-thiouracil.

Discussion

There has long been a need for a better therapy of angina pectoris than the usual treatment of prolonged rest, sedation and vasodilators. It appears that thiouracil answers this need more closely than any form of therapy now at the clinicians' command.

Thiouracil, in our experience, has acted by relieving some of the patients completely of their attacks; whereas in other patients the frequency and severity of the attacks have been diminished. The failure of a patient to respond at all or poorly to thiouracil medication has been explained by the differences in the effect of thiouracil on the thyroid gland.[1] It has been noted that after total thyroidectomy anginal symptoms are not always abolished.[5] Patients with myxedema have shown symptoms of typical angina pectoris. The differences in the results in these cases might also be explained on the extent of coronary sclerosis as well as the "intensity of epinephrine discharges."[9]

We recommend the following regime in treating a patient with angina pectoris, using thiouracil: A basal metabolism test should be performed before therapy is initiated. The patient is then given 3 grains (0.2 gm.) of thiouracil after meals. This is continued until the patient makes an adequate response; namely, does not have pain or the frequency and/or intensity of the attacks has decreased. After a therapeutic response the patient is given 1½ grains (0.1 gm.) after meals and at bedtime. If the patient does not have a relapse of symptoms on this dosage, the drug may be reduced to 1½ grains (0.1 gm.) after meals or twice a day. It must be stressed that no one dosage will suffice for any given patient. In the final analysis the dosage should be judged by the clinical

response. Clinicians have been warned that the use of thiouracil in amounts larger than 0.6 gram per day is extremely dangerous and unwarranted; the smallest dosage of thiouracil possible should be used.

The patient should be seen at three- to four-day intervals during the first three weeks of therapy and should have a hemoglobin determination, red blood cell and white blood cell counts as well as a urinalysis on each visit. If the patient does not show any toxic manifestations as a result of the thiouracil, his office visits may be scheduled at weekly intervals for approximately one month after which he may be seen at two-week intervals. At each office visit, the laboratory data mentioned should be obtained. We do not feel that a patient should be seen at intervals longer than two weeks. A basal metabolism test should be performed bi-monthly. For those patients who are not completely relieved of pain we advise the use of nitroglycerine, 1/100 grain under the tongue when necessary. It has been our experience that those patients who formerly were forced to take two to four nitroglycerine tablets to relieve each attack now find that one tablet will suffice. The patient should be warned to limit his activities even if he is not suffering from severe chest pain. This word of warning is imperative since the mechanism for pain production in angina pectoris has been broken by thiouracil but the degree of coronary sclerosis is not altered; and therefore, an additional burden should not be placed on a diseased myocardium.

Our series of sixteen patients consisted of ten males and six females. The average age at the onset of angina pectoris was 56.5 years. The average duration of angina pectoris before thiouracil treatment was 2.80 years; one patient having suffered from this condition for a period of ten years. The duration of thiouracil therapy per patient up to the time that this article was written was 6.02 months. One patient had been on therapy for seventeen months, a second for sixteen months, and the shortest duration of therapy was one month.

TABLE I

Case Number	Age	Sex	Duration of Angina Before Therapy	Duration of Therapy	Complications	Results
1	59	male	24 months	1¼ months	none	good
2	49	female	66 months	16 months	anemia, leukopenia, myxedema	good
3	59	female	31 months	9¾ months	myxedema	good
4	52	male	48 months	6 months	myxedema, petechiae of skin	good
5	53	male	24 months	8 months	enlarged soft thyroid gland	good
6	63	male	8 months	3 months	none	poor
7	57	male	48 months	1 month	none	good
8	59	male	31 months	4½ months	none	good
9	60	female	8 months	4 months	leukopenia	good
10	60	male	120 months	17 months	myxedema	good
11	44	female	12 months	8 months	none	good
12	65	female	12 months	1½ months	anemia	good
13	53	male	9 months	1½ months	leukopenia	good
14	73	male	36 months	9 months	none	good
15	45	female	38 months	2 months	leukopenia	good
16	59	male	24 months	2 months	none	poor

The clinical responses to treatment were tabulated in Table I.

An analysis of our complications reveals the following: Two patients (No. 2 and No. 12) developed severe anemia, and as a consequence, patient No. 12 had her treatment discontinued. Her blood count fell from an initial 4,080,000 to 3,320,000. The hemoglobin dropped from 78 per cent to 64 per cent. This complication occurred one month after thiouracil treatment was started. Patient No. 2 developed her anemia five and one-half months after therapy was commenced, but this was overcome after a reduction in the dosage of her medicine.

Four patients (Nos. 2, 9, 13, and 15) developed leukopenia five and one-half months, four and one-half months, three weeks, and two and one-quarter months respectively after treatment was initiated. Three of these patients (Nos. 9, 13, and 15) subsequently had their therapy discontinued. Patient No. 2's leukopenia was overcome when the dosage of thiouracil was decreased.

Four patients (Nos. 2, 3, 4, and 10) developed myxedema during the course of their therapy. Patient No. 2 first began to complain of symptoms leading to the diagnosis of myxedema approximately eleven months after her therapy was initiated. Patient No. 3 developed symptoms of myxedema approximately five and three-quarters months after therapy was commenced. Patient No. 4 developed signs of myxedema five and one-half months

after therapy was first started while patient No. 10 was treated approximately fourteen months before the symptoms of myxedema were noted.

Patient No. 5 developed an enlarged, soft, thyroid gland, seven months after therapy was commenced, and two weeks later his blood cholesterol was 222.2 mg. per cent. However, the latter patient had a basal metabolism of plus 3 per cent at the time of enlargement of his thyroid and elevation of his blood cholesterol. At no time did he complain of puffiness of the face, intolerance to cold, slowness of speech, or marked dryness of the skin. Patient No. 4 developed petechiae of the skin five and one-half months after his therapy was started. These disappeared rapidly after his thiouracil was discontinued.

It would appear that there is no therapeutic advantage in creating a myxedematous state since these patients had made adequate clinical responses long before this complication had developed. In fact, the elevated blood cholesterol might be a factor in promoting further coronary sclerosis although many investigators do not entirely accept this theory.

Rabb[9] has shown that the electrocardiogram may return to normal while the patient is on thiouracil therapy. In one of his cases he demonstrated that the pathological changes noted on the electrocardiogram became more pronounced while on this form of treatment. The same author also placed great emphasis on the correlation of the basal metabolic rate and the therapeutic response which he obtained in his patients. In seven of his patients who were either decidedly or completely improved, he noted a decrease of the basal metabolic rate which he believed to be significant and which paralleled the decrease or disappearance of the anginal symptoms. Two of his patients who failed to respond did not show a significant decrease in the basal metabolic rate and one patient who was only slightly improved showed a moderate and a temporary fall in the metabolic rate. He felt that a maximum improvement in the clinical picture was noted when the basal metabolic rate had fallen seven to twenty-seven points below the prethiouracil therapy level. Relapses in the clinical picture occurred with the return of the basal metabolic rate to its original level. The initial basal metabolic level just before thiouracil therapy was started did not appear to influence the effectiveness of the treatment. In an analysis of our cases we were, for the most part, able to substantiate Rabb's findings; however, there were exceptions. Patient No. 16 had a basal metabolic rate of plus 18 per cent three weeks after therapy was initiated. Six weeks after therapy was started, his metabolism test was read as a minus 18 per cent; however, his response was classified as poor. Patient No. 9 had a basal metabolic rate of plus 22 per cent nine days after thiouracil therapy was started. Seventeen days later her basal metabolic rate was plus 31 per cent. The response in this case was good. Patient No. 14 had a basal metabolic rate of minus 1 per cent three weeks after the initiation of thiouracil therapy, and six weeks later his basal metabolic rate was a plus 1 per cent; his response was graded as good. Therefore, it would seem to us that the metabolic rate does not always correlate with the clinical response.

The average number of days from the time of initial treatment until there was a subjective improvement was approximately 13.3 days. One patient required thirty days to make a response, whereas the shortest period was five days. Rabb[9] reported subjective improvement after ten days to six weeks of therapy. The blood pressure findings after thiouracil as compared with the pre-treatment level were indeterminate.

Conclusion

1. Sixteen cases of angina pectoris treated with thiouracil were presented. The results of therapy were as follows: there was a good response in fourteen patients and two patients showed a poor response.

2. The recommended dosage for thiouracil is 3 grains (0.2 gm.) after meals until the patient has made an adequate clinical response after which the drug is reduced to 1½ grains (0.1 gm.) after meals and at bedtime. If there is no relapse of symptoms on this dosage, the drug may be reduced to 1½ grains (0.1 gm.) after meals or twice a day. It is desirable to give as small a dose as possible and yet keep the patient's symptoms at a minimal level.

3. To detect early toxic manifestations of thiouracil the patient should be seen at three- to four-day intervals during the first three weeks of therapy and at weekly intervals for approximately one month afterwards. The office visits may then be made at two-week intervals. At each office visit there should be a hemoglobin determination, red blood cell and white blood cell counts and a

urinalysis. A basal metabolism test should be performed bi-monthly.

4. Adjunctive therapy should consist of nitroglycerine, 1/100 grain when necessary, in those patients who are not completely relieved of their attacks. In addition, the patient should make an attempt to restrict his activities, especially in those patients not having pain.

5. If the patient develops such major complications as severe anemia, and leukopenia, thiouracil therapy should be continued with small doses and if the condition does not correct itself, thiouracil therapy should be discontinued. Myxedema is an annoying complication and should not be created since the patient will respond before this level is reached. When myxedema develops, the drug should be reduced until the condition is corrected. We do not feel that it is necessary to discontinue the drug entirely in order to overcome this condition.

6. The basal metabolic rate is closely correlated with the clinical response that the patient may be expected to show. This, however, is not 100 per cent and, therefore, therapy should be continued even though the metabolic rate does not fall. Occasionally patients with a fall in their metabolic rate show a poor response to this form of therapy.

7. While administration of thyroid extract tended to correct resultant myxedematous states, it was noted that the beneficial effect of thiouracil was correspondingly decreased.

8. The average number of days from the time of initial treatment until there was a subjective improvement was 13.3 days. One patient did not respond until a lapse of thirty days. A period of six weeks has been found necessary by another investigator before improvement took place.[9]

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Bibliography

1. Astwood: Cited by Rabb.[9]
2. Ben-Asher, S.: The treatment of anginal syndrome with thiouracil. J. M. Soc. New Jersey, 42:401-406, (Dec.) 1945.
3. Brunschwig, Humphreys and Roome: Cited by Rabb.[9]
4. Cannon, W. B.: Cited by Rabb.[9]
5. Claiborne and Hurxthal: Cited by Rabb.[9]
6. Eppinger and Levine: Cited by Rabb.[9]
7. Lenhartz: Cited by Rabb.[9]
8. Levine, Ernstene, and Jacobson: Cited by Rabb.[9]
9. Rabb, Wilhelm: Thiouracil treatment of angina pectoris. J.A.M.A., 128:249-256, (May 26) 1945.
10. Rabb: Cited by Rabb.[9]
11. Rabb and Soule: Cited by Rabb.[9]
12. White, Paul Dudley: Heart Disease. Third edition, pp. 842-844. New York: The Macmillan Co., 1944.

Inversion of the Uterus

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Acute puerperal inversion of the uterus occurs, according to Das, one in 27,992 deliveries in British hospitals; and one in 8,532 deliveries in Indian hospitals. It occurs according to Harer and Sharkey, one in 16,240 deliveries; according to Irving, one in 7,800 deliveries; according to Stander, one in 4,000 deliveries; and in our experience, one in 1,000 deliveries.

Etiology

Das,[1] reviewing 297 collected cases, states that 40 per cent are spontaneous, 21 per cent followed traction on the cord, and 19 per cent resulted from improper expression of the placenta. The placenta was found to be adherent to the fundus in 75 per cent of the cases. He believes that the conditions necessary for inversion are:

1. Sudden emptying of the uterus after distention of its cavity.
2. Thinning of its walls by the gradual development within it of some tumor.
3. A dilated cervix.

Harer and Sharkey[3] believe that "the most frequent cause of inversion of the uterus is suprafundal pressure applied to a relaxed uterus in an effort to expel the placenta." In their report of twenty-one cases they state that 76 per cent were due to errors of technique. Irving[5] is of the opinion that most cases are spontaneous. Stander[7] states, "The accident is excessively rare when labor is properly conducted. . . ."

Symptoms

Shock is disproportionate to blood loss.[2] Harer and Sharkey[3] state, "Within a few minutes after an acute inversion of the uterus, a previously normal woman is in an extremely precarious condition—the pulse rate averaged 160 per minute." Irving[5] believes that "pain is seldom present." According to Stander,[7] "As a rule, inversion of the uterus is promptly followed by alarming symptoms, the patient presenting evidence of shock out of proportion to the amount of blood lost, with a

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rapid pulse and a tendency to syncope. In other cases convulsions occur and profuse hemorrhage is frequently noted. On the other hand, the symptoms are sometimes very slight." Titus[9] states, "A complaint of sudden pain during or soon after the third stage, followed by shock, should always suggest the possibility of inversion of the uterus."

Mortality

The mortality rate is given by Das[1] as 14.8 per cent; by Harer and Sharkey as 43 percent; by Irving[5] as around 16 per cent; in our experience of one case, 100 per cent.

Differential Diagnosis

Acute puerperal inversion of the uterus usually presents the picture of profound shock and hemorrhage as mentioned above. Physical examination will show the rough, bleeding, mass in the vagina with absence of the uterus in the lower abdomen. However, if the condition is not discovered immediately after completion of the third stage of labor and before pelvic examination is carried out, one must consider the other accidents of labor which we list from Irving[5] as follows:

1. Postpartum hemorrhage, due to:
   (a) atony of the uterus,
   (b) retention of the partially separated placenta,
   (c) lacerations of the generative tract.
2. Shock, following normal operation or toxemic delivery.
3. Acute dilatation of the stomach.
4. Acute edema of the lungs.
5. Massive collapse of lungs.

Treatment

DeLee and Greenhill[2] recommend manual replacement of the uterus immediately if the inversion is discovered at once; otherwise the shock is treated, then manual replacement is attempted. Harer and Sharkey[3] advised immediate manual replacement. McLennan and McKelvey[6] advised that the patient be treated for shock and that no attempt be made to correct the inversion for some time. In the discussion following this paper, Harer reported on twenty-five cases of inversion of the uterus, fifteen of which were treated by immediate replacement, with thirteen of these fifteen patients surviving. Of five cases treated by intermediate manual replacement all five died.

Huntington, Irving and Kellogg[4] reported five cases of acute puerperal inversion of the uterus where the uterus was replaced by abdominal operation, all of which lived. Two cases were operated upon two hours after delivery; one, four hours after delivery; one, ten hours after delivery; and one, thirty-six hours after delivery. They[4] explained the operative techniue: "The operator and his assistant are both armed with two Allis forceps. Each inserts one of his forceps into the crater for about an inch and grasps the surface of the uterus on his side. Both draw upward simultaneously, pulling a portion of the uterus out of the ring and restoring it to the peritoneal cavity. Steadying the uterus by the forceps already applied, the operators now insert their second forceps into the crater for about the same distance as before, again grasp the sides of the uterus and pull upward. Then by successive bites and upward traction, the uterus is gradually restored to its normal position in the abdominal cavity."

Stander[7] advises immediate manual replacement if possible; if patient is in severe shock this should be treated first. If the patient is seen after the cervix is contracted and manual replacement is impossible, the above described operation is recommended.

Case Report

The patient, Case No. 25,836, a white, married twenty-four-year-old primipara, was admitted to the hospital at 1:00 A.M., February 14, 1947, at term and in labor. She was the patient of a visiting physician. The pregnancy had been normal throughout. The blood pressure had remained below 120/80 millimeters of mercury. The urine had been free of protein and sugar, and the weight gain during pregnancy was not excessive.

Menstrual History.—Menarche at fourteen years of age; the periods had been regular every twenty-eight days but with profuse menstruation lasting six to eight days. She complained of dysmenorrhea. The L.M.P. began on May 9, 1946; the E.D.C. was February 16, 1947.

Past History.—The patient had been treated at this hospital for various complaints. On September 2, 1930, she was treated for fracture of the left clavicle and humerus. On October 19, 1942, a dilatation of the cervix and curettage of the uterus was performed because of excessive menstruation and dysmenorrhea. The pathologists's report of the tissue obtained was: endometrium atrophic and in a resting phase.

On December 26, 1944, she had an excision of tumors of the left breast. The pathologist's report was pericanalicular and intracanalicular adenomyofibroma;

no malignancy. On June 24, 1945, an appendectomy was done. The pathologist's report was: chronic appendicitis. On March 11, 1946, simple mastectomy of the left breast and a partial mastectomy of the right breast were done. The pathologist's report: diffuse adenofibromatosis. No malignancy.

Course in Labor.—Labor had begun at 8:00 A.M. on February 13, 1947. The patient was admitted to the hospital at 1:00 A.M., on February 14, and, at 4:20 A.M., after a normal first and second stage, had a spontaneous delivery from the R.O.A. position, of a normal baby boy, weighing 6 pounds 8 ounces. Pituitrin was given at the end of the second stage of labor. The third stage lasted forty minutes. The placenta was reported as being adherent. The placenta was expelled intact. Ergotrate was given and then repeated because of vaginal bleeding.

Postpartum Course.—Upon return to her bed at 5:00 A.M., on February 14, the patient began to complain bitterly of epigastric pain. The pain was in the upper abdomen. Morphine sulfate, grain ⅙, was given without relief. This was repeated at 5:30 A.M. but the severe epigastric pain continued, and morphine sulfate, grain ¼ was given at 8:00 A.M. The nurse reported that she could not feel the uterus.

The patient was first seen by a staff physician at 8:30 A.M., three and one-half hours after completion of labor. She was found to be in profound collapse; the pulse and blood pressure were imperceptible, the apical heart rate was 160 per minute, and her respirations were gasping. At about this time she had a convulsion. She was given 500 c.c. of plasma immediately and this was followed by 1,000 c.c. of a 5 per cent solution of glucose in saline while preparations for blood transfusions were being made. Pure oxygen by mask was administered continuously and the foot of the bed was elevated. Intravenous ergotrate was given as a continuous vaginal ooze of blood was noted. We considered the situation to be one of postpartem hemorrhage although rupture of the uterus was thought of. At this time a catheterized specimen of urine was protein and sugar free; examination of the blood showed the hemoglobin to be 40 per cent, the red blood cells, 2,900,000.

She received 500 c.c. of whole blood at 10:00 A.M., resulting in slight improvement. The blood pressure rose to 80/40 mm. mercury, but the pulse could not be obtained; the apical beat remained rapid, and the respirations continued to be gasping in character. The patient remained unconscious.

Because of failure to respond to treatment, a sterile vaginal examination was done at 11:00 A.M. A large, spongy, round mass was found to occupy the vagina. The external os could not be found. The uterus was absent supravaginally, and the diagnosis of complete, acute, puerperal inversion of the uterus was made. The cervix had contracted and the uterus was so firm that manual replacement was impossible. Abdominal replacement was decided upon.

Another 500 c.c. of whole blood was given, which was followed by a rise in the blood pressure to 110/60 pulse was 130 per minute, although the patient remained unconscious.

Abdominal replacement by the method of Huntington[4] under local anesthesia was easily and rapidly carried out at 1:00 P.M. on the same day. Following the operation the patient improved slightly. She was given 1,000 c.c. of whole blood, 1,000 c.c. of 10 per cent glucose in water, and penicillin, 100,000 units every two hours. The blood pressure rose to 128/70, the apical beat 130 to 150 per minute, the temperature rose to 103° F. rectally. She was digitalized prophylactically. She became responsive for about one hour. The red blood cell count rose to 3,800,700; the hemoglobin was 67 per cent.

At 10:00 P.M. that day, the blood pressure fell to 70/40, the apex beat rose to 160 per minute, and temperature was 103° F. rectally. The respirations continued to be gasping. She received 1,000 c.c. of plasma during the night with some improvement. Marked oliguria developed.

At 9:00 A.M., on February 15, the patient again relapsed, the blood pressure falling to 70/40 mm. mercury. The apical beat was 160 per minute, and the rectal temperature was 103° F. She was given 500 c.c. of whole blood and 500 c.c. of a 20 per cent solution of glucose in water, plus 100 c.c. of a 50 per cent glucose solution. Improvement was noted that day, the blood pressure remaining above 110/70, but the heart beat remained very rapid, 130 to 150 per minute. The temperature rectally was 102.° F. The respirations remained very bad, and the patient did not regain consciousness.

At 10:30 P.M. that day the blood pressure began to drop again, and the apical heart beat rose to 160 per minute; 500 c.c. of plasma and 500 c.c. of 20 per cent glucose in water was given. The blood pressure rose to 110/70 but the response was weak. The patient was practically anuric, only 3 ounces of urine being collected in thirty-six hours. There was generalized, non-pitting edema but no pulmonary edema.

On February 16, at 8:00 A.M., she was given 500 c.c. of whole blood to which she did not respond. The blood pressure was 70/40; the apical heart beat 160 per minute, and the rectal temperature, 102° F. Cyanosis of the extremities increased. At noon that day she had a large defecation and vomited copiously. The patient expired at 2:45 P.M. on February 16, 1947.

Discussion

We believe that this patient sustained irreparable damage between 5:00 A.M. and 8:30 A.M. on February 14. The poor response to multiple transfusions, the gasping respirations, the continuous coma and the rapid pulse, all of which were present when we first saw the patient and continued throughout the course of the illness, tend to sustain this concept.

(References on Page 1075)

A New Sulfonamide—Sulfamylon

Its Topical Use in Upper Respiratory Disease

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Sulfamylon is a white crystalline material which is freely soluble in water (50 gm. per 100 c.c. at 25° C.). Its chemistry is as follows:

4-Aminomethylbenzenesulfonamide hydrochloride

$$H_2NSO_2 \longleftrightarrow CH_2NH_2.\ HCL$$

Its aqueous solutions are weakly acidic. Table I[8] shows the pH.

TABLE I. pH OF AQUEOUS SOLUTIONS OF SULFAMYLON

Per Cent Concentration	pH of Solution
1.0	5.5
2.0	5.4
20.0	5.1

This compound is a sulfonamide derived from benzylamine and differs from sulfanilamide in that a methylene group has been inserted between the benzene ring and the 4-amino group. Because of the presence of this methylene group in its molecule, the antibacterial activity of Sulfamylon is not inhibited by p-aminobenzoic acid, and its mode of action would, therefore, appear to differ from that of the common sulfonamides (sulfanilamide, sulfathiazole, et cetera). Experimental work[8] *in vitro* covered many organisms such as anaerobes, *Clostridium welchii, Cl. botulinum,* and others in this group are shown to be effective in dilutions as great as 1:25,000, compared to 1:100 dilution of sodium sulfathiazole which was comparatively ineffective. When tested against aerobic bacteria it was found especially effective.

Gram-Positive Cocci.—The results of further studies[8] on the antibacterial effects against gram-positive cocci are given in Table II. Sulfamylon proved to be fully as active against *Streptococcus hemolyticus* C-203 and pneumococcus Types I, II, and III as sodium sulfathiazole, and considerably more active than sodium sulfadiazine. Sulfamylon was definitely bacterio-static and bactericidal to two strains of *Streptococcus viridans,* and showed some inhibitory action on *Streptococcus faecalis,* whereas the other sulfonamides gave no suggestion whatever of antibacterial action against these organisms.

Antibacterial Action in the Presence of p-Aminobenzoic Acid and p-Aminomethylbenzoic Acid.—In contrast to its inhibitory action on sulfanilamide, sulfathiazole, sulfadiazine, et cetera, p-aminobenzoic acid fails to inhibit the antibacterial action of Sulfamylon *in vitro.* Schreus[9] first observed this inability of p-aminobenzoic acid to act as an antagonist to Sulfamylon in 1942, and this work has been confirmed by McKee et al,[7] Clark,[2] Domagk[3,4] and Lawrence.[6]

In attempting to explain the possible mechanism of action of Sulfamylon (p-aminomethylbenzenesulfonamide) against anaerobic bacteria, Schreus[9] postulated that while p-aminobenzoic acid is not concerned with the action of the Sulfamylon, the analog of p-aminobenzoic acid, namely, p-aminomethylbenzoic acid, is the metabolite which should compete with Sulfamylon for the growth of the organisms.

The possible antagonistic action of both p-aminobenzoic acid and p-aminomethylbenzoic acid upon the antibacterial effects of Sulfamylon against *CL. welchii* were studied[8] by the following *in vitro* methods: Serial dilutions of the latter compound were made in Brewer's thioglycollate medium[1] containing a 1:500 concentration of one of the benzoic acids. This amount of p-aminobenzoic acid has been found to inactivate completely the antibacterial effects of all the commonly known sulfonamides (sulfanilamide, et cetera). Suitable controls containing Sulfamylon

Drugs were supplied by Winthrop Chemical Co., New York, New York.

Sulfamylon has been described in the British and German literature as Homsulfanilamide and Marfanil.

TABLE II. HIGHEST DILUTIONS OF SULFAMYLON, SODIUM SULFATHIAZOLE, AND SODIUM SULFADIAZINE SHOWING ANTIBACTERIAL EFFECTS AGAINST VARIOUS GRAM-POSITIVE COCCI.

Organisms	Sulfamylon		Sodium Sulfathiazole		Sodium Sulfadiazine	
	Bs	Bc	Bs	Bc	Bs	Bc
Strep. homolyticus C-203	1:32,000	1:8,000	1:8,000	1:4,000	1:2,000	V 1:1,000
Pneumococcus Type I	1:32,000	1:4,000	1:32,000	1:4,000	:8,000	1:1,000
Pneumococcus Type II	1:32,000	1:16,000	1:32,000	1:8,000	1:4,000	V 1:1,000
Pneumococcus Type III	1:32,000	1:8,000	1:32,000	1:4,000	1:16,000	V 1:1,000
Strep. viridans 74	1:16,000	1:400	V 1:100	V 1:100	V 1:100	V 1:100
Strep. viridans 1454	1:8,000	1:4,000	V 1:100	V 1:100	V 1:100	V 1:100
Strep. faecalis 7080	1:400	V 1:100	V 1:100	V 1:100	V 1:100	V 1:100
Strep. faecalis 4080	1:400	V 1:100	V 1:100	V 1:100	V 1:100	V 1:100

Bs — Bacteriostatic Bc — Bactericidal
Figures preceded by V indicate highest drug concentration tested proved ineffective.

without the benzoic acid, as well as the latter alone were maintained throughout the tests. The results of a typical series of these tests are shown in Table III.

It is evident from the data in Table III that neither p-aminobenzoic acid nor p-aminomethylbenzoic acid proved to be antagonistic to the antibacterial effects of Sulfamylon against the anaerobe, *Cl. welchii*.[10] Although not reported here, experiments were carred out which show that under the same experimental conditions similar results were obtained with the other anaerobes, such as *Cl. welchii, Cl. histolyticum, Cl. oedemations, Cl. septicum, Cl. novyi, Cl. tetani, Cl. chaubei*, and *Cl. botulinum*.

In further experiments the effects of p-aminobenzoic acid and p-aminomethylbenzoic acid upon the antibacterial actions of Sulfamylon and sulfathiazole against *Streptococcus hemolyticus* C-203 were compared.[8]

Data indicated that p-aminobenzoic acid and p-aminomethylbenzoic acids are not antagonistic to the antibacterial effects of Sulfamylon against *Streptococcus hemolyticus* C-203 in an anaerobic medium. On the other hand, p-aminobenzoic acid completely neutralized the antibacterial action of sodium sulfathiazole.

The presence of relatively large amounts of vitamins, amino acids, peptones, and carbohydrates in the test medium also failed to interfere with the action of Sulfamylon on *Clostridium welchii*.[10]

Toxicity

Acute Oral Toxicity—Mice.—When given perorally to mice in a dosage range of from 2 to 10 grams per Kg. of body weight there was no evidence of toxic effects. Preliminary experiments indicate that the oral LD is between 12 and 13 Gms./Kg.

Subacute Oral Toxicity—Mice.—Hamre[5] and coworkers have shown the effects of continued administrations of Sulfamylon and sulfanilamide on mice fed on diets containing 1, 2 and 4 per cent of the former and equivalent levels (0.775, 1.55 and 3.1 per cent) of the latter for twenty-eight days. The weight curves demonstrate little difference in the chronic toxicity of the two compounds at the two lowest levels. At the highest level sulfanilamide had a distinctly more deleterious effect that Sulfamylon on the growth rate. All surviving animals were sacrificed on the twenty-eighth day for examination. The spleens of all mice receiving sulfanilamide were congested and slightly enlarged. Except for one mouse on the diet of 4 per cent of Sulfamylon, in which the spleen and kidneys were pale, no other gross changes were observed. Histologic study of the liver, kidney and spleen of four mice on each diet revealed that the only significant changes in the livers of mice receiving Sulfamylon was a slight degree of fatty infiltration. This occurred in mice receiving the higher dose level. All mice receiving sulfanilamide were found to have hyperplastic spleens with large deposits of hemosiderin which was also prominent in sections of the livers. One mouse on 4 per cent Sulfamylon had a hydronephrosis apparently due to drug obstruction. This was observed in another mouse but to a much less pronounced degree. Tubular dilations, apparently due to drug obstruction, were also found in the kidneys of two mice on the highest diet level of sulfanilamide.

Local Tolerance.—Solutions of Sulfamylon of 0.1, 0.5, and 2.0 per cent were tested for possible irritation to the conjunctival mucosa of rabbits. Each solution was applied to the right eye of two rabbits, while the left eye of the same rabbit served as a control. One group of rabbits received one

TABLE III. EFFECTS OF P-AMINOBENZOIC ACID AND P-AMINOMETHYLBENZOIC ACID UPON ANTI-BACTERIAL ACTION OF SULFAMYLON AGAINST CLOSTRIDIUM WELCHII

Sulfamylon Dilution	Sulfamylon											
	Control				PABA				PAMBA			
	24	48	72	S	24	48	72	S	24	48	72	S
1:1,000	0	0	0	0	0	0	0	0	0	0	0	0
1:2,000	0	0	0	0	0	0	0	0	0	0	0	0
1:4,000	0	0	0	0	0	0	0	0	0	0	0	0
1:8,000	0	0	0	+	0	0	0	0	0	0	0	0
1:16,000	0	1	1	+	1	1	1	+	1	1	1	+
1:32,000	1	4	4	—	1	2	4	—	1	4	4	—
1:64,000	2	4	4	—	3	4	4	—	3	4	4	—

PABA = p-Aminobenzoic acid, 1:5,000
PAMBA = p-Aminomethylbenzoic acid, 1:5000
S = Subculture
O = No visible growth; 1 to 4 = slight to luxuriant growth
+ = Growth in subculture tube — = No test made.

application and showed no evidence of irritation. A second group of rabbits were then treated five times during the afternoon, at approximately one-half hour intervals, and were again treated five times, at one-half hour intervals, the next morning. There was no evidence of any irritation even after this repeated application of 0.1, 0.2, 1.0, and 2 per cent solutions of Sulfamylon.

Classification of Cases

Table IV* presents twenty-eight private patients treated with Sulfamylon. They represent an age range of from three years to sixty-seven years. There are eleven cases of chronic sinusitis, one case of subacute sinusitis, one case of acute sinusitis, nine cases of acute rhinitis, one case of subacute rhinitis, one case of atropic rhinitis, two cases of hyperthrophic rhinitis, one allergic rhinitis, one sinusitis with ethmoidal polyps. Allergic findings were also found in fifteen cases of the sinus group. Two had nasopharyngitis, two had complicating purulent otitis media, one had tonsillitis and in one case it was used as a preoperative medication in a submucous resection.

Medication

Sulfamylon solution comes in a 4 per cent solution and also in a 1 per cent Sulfamylon solution modified by the addition of ¼ per cent neosynephrin solution.

The neosynephrin combination was used only when there was an anterior nasal block.

Method of Administration.—Sulfamylon treatment consisted of free instillation of either solution by the Proetz technique. Local application to the pharynx and tonsils was used in three cases.

Results

All patients in this series reported improvement—the acute cases as soon as eight to twenty-four hours after commencement of their treatment, while the chronic cases also responded well subjectively. The patients' reports were checked by examination and these are recorded. The acute cases responded promptly, as was manifested by examination which revealed less drainage, less swelling and better nasal ventilation. The chronic cases revealed improvement, but not as dramatic. The swelling and discharge was present, lessened in amount and viscosity, drainage freer. There was a tendency of symptoms and findings to recur in the purulent ethmoiditis and polyp cases after medication was discontinued.

*See following page.

Conclusions

This report must be considered in the nature of a preliminary report on the use of Sulfamylon in upper respiratory disease. Twenty-eight cases are presented. There were no untoward reactions either locally or systemically. Further study is needed to evaluate Sulfamylon on diseases of the upper respiratory tract. Bacterial studies before and after "medication" are still lacking. Subjectively all patients reported improvement—the acute cases responded best and the complicated sinus cases the least.

References

1. Brewer, John H. Ph.D.: Clear liquid mediums for the "aerobic" cultivation of anaerobes. J.A.M.A., 115:598, 1940.
2. Clark, W. G.: Unpublished data.
3. Domagk, G.: Bull. War Med., 4:300, 1944.
4. Domagk, G.: Deutsche. med. Wchnschr., 69:379, 1943.
5. Hamre, Dorothy M.: Walker, H. A.; Dunham, Wolcott B.; van Dyke, H. B., and Rake, Geoffrey: Chemotherapy of infections with Cl. perfringens in mice by Homosulfonamides.
6. Lawrence, C. A.: In vivo studies on the antibacterial actions of para-aminomethylbenzenesulfonimide derivatives. J. Bact., 49:149, 1945.
7. McKee, C. M.; Hamre, D. M., and Rake, G.: The action of antibiotics on organisms producing gas gangrene. Proc. Soc. Exper. Biol. & Med., 54:211, 1943.
8. Research (Medical Laboratories) Winthrop Laboratories, Buffalo, New York.
9. Schreus, H. Th.: Klin. Wchnschr., 30:671, 1942.
10. Siebermann, Charles O., and Plummer, Helen: Chemotherapy and antitoxin therapy of experimental Cl. welchii infection in mice. J. Pharmacol. & Exper. Therap., 83:71, 1945.

TABLE IV. SULFAMYLON

Case No.	Name	Sex	Age	Complaint	Duration	Diagnosis	Examination	Discharge	Post-Nasal Drip	Sinuses	Allergy	Blood Pressure	Re-action	Previous Treatments	Results
1	W.W.	M	16	Nose blocked	10 years	Chronic sinusitis, allergic nose	Postoperative Slight posterior deviation	Watery mucous	Yes	Ethmoids dark	Yes	110/68	None	Submucous resection Vaccine Usual nose drops	Improved x
2	C.L.	M	59	Nose blocked	Over 20 years	Chronic sinusitis, allergic nose	Slight deviation	Thick mucous	Yes	Ethmoids, maxillary dark	Yes	105/65	None	Vaccine and local nose packs	Improved xx
3	R.C.	M	29	Nose, cars blocked Throat raw	5 days	Acute rhinitis Pharyngitis Tubal block	Negative	Watery	Yes	Negative	No	118/76	None	None	Improved xxx
4	E.B.	M	3	Head cold Left ear discharge	3 weeks	Acute rhinitis Left purulent otitis	Deviation	Pus and mucous	Yes	Maxillary dark	No	78/54	None	Penicillin and sulfa internally	Improved xxx
5	T.D.	M	22	Head cold Sore throat	On and off, 10 years. Recent, 1 week	Acute sinusitis Pharyngitis	Left complete block. Deviation	Pus and mucous	Yes	Left frontal and left maxillary dark	Yes	130/70	None	None recently	Improved xxx
6	D.M.	F	21	Migraine Nose block Nose bleeds Sneezing	2 months	Subacute sinusitis	Slight deviation	Glue like	Yes	Ethmoids, maxillary dark	Yes	122/84	None	None	Improved x
7	E.J.	M	27	Nose bleeds Nose block	2 years	Deviated septum Nose "block"	Deviation S-shape	Mucous	Yes	Negative	No	116/70	None	Cautery	As pre-surgical "Cleaner" to nose
8	B.K.	M	67	Nose blocked Snores Scabs in nostrils	12 years	Atrophic rhinitis	Pale turbinates with crusts and mucus	Thick mucous	Yes	All transilluminate fair	Yes	156/92	None	Window and submucous resection	Improved x
9	A.C.	M	33	Left ear blocked Nose blocked	4 years	Hypertrophic rhinitis	Strawberry red turbinates Pharyngitis	Thick mucous	Yes	Negative	No	132/86	None	Any nose and ear drops	Improved x
10	D.F.	F	35	Headache and pain under left eye	1 year	Allergic nose	"Hyper" turbinates Thick mucus	Mucous	Yes	Left frontal and left maxillary dark	Yes	120/82	None	Other sulpha nose drops	Improved x
11	G.	F	46	Nose blocked	"Many" years	Polypoid ethmoiditis Chronic sinusitis	Large polyps with thick mucus	Thick mucous	Yes	Ethmoids and maxillary sinusitis	Yes	138/88	None	Operation and usual post-operative care	Improved x
12	M.S.	F	7	Nose cold	2 weeks	Acute rhinitis	Turbinates swollen	Watery mucous	Yes	Swollen mucous membranes and mucous watery discharge	No	86/64	None	Recent eye operation	Improved xxx
13	M.M.	F	42	TRO Facial pain	2 weeks acute phase	Allergic nose and acute rhinitis	Right side complete block	Watery	Yes	Maxillary dark	Yes	144/86	None	None	Improved x
14	M.W.	F	61	Nose blocked Colds	On and off several weeks	Acute rhinitis	Allergic nose, thick swollen mucous membranes	Watery	Yes	Negative	Yes	158/88	None	Nose and allergic medication	Improved x

15	E.D.	F	35	Continually running nose	On and off, 10 years	Chronic sinusitis	Allergic nose Rhinitis	Watery	Yes	Maxillary and ethmoids	Yes	116/76	None	Usual nose drops	Improved x
16	I.G.	M	30	Sore throat Head cold	1 month	Subacute rhinitis Tonsilitis	Follicular tonsilitis Right tonsil tag	Mucous Pus	Yes	Maxillary dark	No	120/70	None		Improved xx
17	B.G.	M	55	Alternating nose block with thick discharge	Several months	Chronic purulent sinusitis	Sinusitis Purulent	Thick mucous Pus	Very marked	All dark	No	110/65	None	Oral vaccine	Improved x
18	R.C.	F	39	Head cold	Several weeks	Acute rhinitis	"Hyper" turbinates Thick pus	Thick mucous	Yes	None	No	114/70	Good	None	Improved xx
19	L.R.	F	43	Frontal head aches Head colds	Several years	Chronic sinusitis	Chronic sinusitis	Mucous	Yes	No darkness Maxillary translucent	No	138/86	None	None	Improved x
20	R.P.	M	53	Nose bleeds Nose blocked	Several years	Chronic sinusitis Purulent ethmoiditis	Pus in mid-frontal. Large turbinates Deviated septum	Pus	Yes	Ethmoids and Maxillary dark	Yes	110/60	None	None	Improved x
21	W.K.	F	30	Head colds Difficulty in breathing	1 year	Acute rhinitis	Deviated septum Pale mucous membranes	Thick mucous	Yes	Ethmoids dark	Yes	110/70	None	Nose drops	Improved xx
22	E.R.	F	43	Headaches and alternately nose block	Several years	Chronic sinusitis Allergic nose	Allergic nose	Watery and mucous	Yes	No darkness Maxillary translucent	Yes	120/80	None	Nose drops	Improved x
23	W.R.	M	46	Nose blocked and sore throat	Several years	Chronic sinusitis Catarrhal nose	"Hyper" turbinates	Thick mucous	Yes	Maxillary dark	No	116/76	None	Vaccine and nose packs	Improved x
24	S.E.B.	M	21	Nose blocked	Several years	Catarrhal nose, Hypertrophic rhinitis	"Hyper" turbinates	Thick mucous	Yes	No	No	122/80	None	Vaccine and penicillin	Improved x
25	R.T.	M	4	Cold, pain in right ear	3 days	Nose blocked & acute otitis media Acute rhinitis	Rhinitis otitis media	Thick mucous	Yes	Cloudy	Yes Hay fever	90/60	None	None for this complaint	Improved x
26	J.F.	M	44	Nose blocked and cough Frontal headache	Many years	Chronic sinusitis	Rhinitis edema of mucous membranes	Thick mucous	Yes	Frontals dark	No	112/70	None	None	Improved x
27	R.G.	F	10	Nose blocked Nose cold	4 days	Acute rhinitis	Thickened acute mucous membranes	Thick mucous	Yes	Negative	No	106/78	None	None	Improved x
28	P.S.	M	52	Nose blocked and cough Frontal headache	25 years	Chronic rhinitis	"Hyper" turbinates with thick mucus	Thick mucous	Yes	Maxillary dark	Yes	120/80	None	Vaccine and nose packs	Improved x

X Improved XX Good Improvement XXX Marked Improvement

Foreign Bodies of the Cornea

By William B. Hubbard, M.D., F.A.C.S.
Flint, Michigan

FOREIGN BODIES of the eye is one of the most frequent conditions about which a physician is consulted. When these are in the cornea, most physicians, if they so desire, can with a little practice very easily diagnose and remove the usual superficial, recently acquired ones.

The most usual difficulty encountered in these cases is the lack of realization that proper illumination is necessary and the lack of knowledge of how to get it.

A local anesthetic must be used. This need of anesthesia and the method of obtaining it is better understood than illumination, but it is not understood by all.

Not so well known is the fact that magnifiers are also very desirable.

Eye physicians usually have little trouble in seeing a foreign body. The room should be neither bright nor dark. The light should come from the side, that is, should strike the patient's eye from an angle. The occasional operator does not always realize this. A beam of light two inches more or less in diameter is good and better than a diffuse light. A Coakley type or smaller spot light does very well. The Brady light has a focussing attachment. A spotlight on the operator's head is very poor as the light is reflected back into the operator's eyes. The same small bright narrow beam, however, held in the hand or mounted on a stand and spotted on the patient's cornea from an angle will usually reveal a foreign body if present. The patient should keep both eyes open if possible. Having the patient turn or rotate his eyes helps to bring the foreign body into the operator's line of vision. The patient is then asked to fix his eyes at this point of best visibility for the operator.

Most books on diseases of the eye describe oblique illumination of the cornea as examination with a convex lens held in one hand between a light coming from one side and the patient's eye. They then advise removal of the foreign body by oblique illumination. It is often impossible for one person to remove a foreign body when one hand is holding a lens in this way. In reviewing a number of old textbooks this same method is found described. With the number of lights now on the market able to focus a bright narrow beam on the cornea from any angle, the hand lens is unnecessary in the usual case. Two hands are thus available. It is hoped that this more practical method of illumination will be included in the texts of the near future.

Butyn, 2 per cent, dropped on the cornea, is one of the many local anesthetics that gives excellent anesthesia. Removal of the foreign body can be carried out as soon as the slight stinging ends, or after about one minute.

Magnifiers are very helpful. The thicker the magnifiers the stronger the light needed. The "magnifocuser," obtainable at any supply house, though not as good as a loupe, is easy to use and works very well even with a poor light. The newer loupes are greatly improved in that they fit over glasses and are designed so that the operator has normal vision to see such things as tables and instruments.

Cases difficult to handle include: old foreign bodies, those deeply imbedded, those extremely minute, those in children, patients who "can't stand to have my eye touched," and the occasional unco-operative patient who persists in flinching or turning his eye every time it is approached with an instrument. These are often referred to eye physicians. Especially in these cases can the eye physician remove the offending object with less trauma to the adjacent cornea. In some of these complicated cases the use of the combined biomicroscope and slit lamp is almost a necessity.

In foreign bodies of the eye, it is well, for future reference, to record the time and place of injury, and the location of any foreign body removed.

The patient's head must be firmly fixed before removal is attempted. A head rest is needed. In an emergency the patient can be seated in a chair

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Dr. Hubbard, with Dr. K. W. Cosgrove, published the first American papers on the now widely investigated experimental burns of the eye.

I. Cosgrove, K. W., and Hubbard, W. B.: Acid and alkali burns of the eye. Ann. Surg., 87:89-94, (Jan.) 1928.
II. Hubbard, W. B.: Treatment of caustic burns of the eye. Arch. Ophth., 18:263-266, (Aug.) 1937.
III. Hubbard, W. B.: Treatment of caustic burns of the eye. Arch. Ophthal., 19:968-975, (June) 1938.

with the back of his head steadied against the wall of a room.

Seldom should an attempt be made to wipe a foreign body from the cornea. Unless very loose, much trauma is done to a large surrounding area of epithelium. An eye knife or spud should be used and should approach the foreign object from the side. Almost any knife designed for the purpose is satisfactory. In an emergency, a sterile hypodermic needle attached to a small syringe suffices. If rust remains in the wound, clinical healing is hastened by its removal. It may be picked or scraped out. Or the spot can be touched with trichloracetic acid on the point of a sharpened tooth pick by an experienced operator. Some prefer to remove the rust with a small dental burr. An interesting subject for experimental investigation would be comparison of healing of rust spots after knife, trichloracetic acid, and burr treatment.

The operator's hands should be clean. The knife, however, touches the patient's cornea and should be unquestionably sterile. Placing it in a flame produces rapid sterilization but would soon ruin the point. The tip of the knife should be examined frequently for sharpness. This can be done with satisfaction with a magnifier.

The usual case would progress satisfactorily without after care. Often an antiseptic ointment or solution is given. One should be sure they are sterile. An eye pad may be applied, especially if there will be any exposure to dirt and dust. To do the most good, an eye pad should be applied sufficiently firm to prevent winking under it. Often an eye pad is quite uncomfortable to some, while others like them. Some physicians sensibly apply a pad and permit the patient to remove it if bothersome.

After removal of a foreign body the patient should be instructed to report the following day, if any pain is present, as this may indicate beginning infection of the cornea.

Often a patient thinks he has a foreign body in his eye when on examination one is not readily seen. Mention should be made of these cases.

Three common things are likely: a hard to find foreign body, an abrasion of the cornea, or an acute conjunctivitis. Instill a local anesthetic to make examination easier. Follow this with a stain such as 1 to 5 per cent mercurochrome or the standard fluorscein eye stain. Wash out the excess with boric, saline, or water, or wait five minutes for it to become diluted by tears. A foreign body, not visible before, may now be seen. Or there may be a red or green spot or line, which may indicate at once that the patient's trouble is due to a cut or scratch of the cornea. If this is the case, it might be mentioned that analgesics, antiseptics, and rest of the eyes is usually curative. Healing usually requires two to three days. If neither a foreign body nor abrasion is found, acute conjunctivitis is likely. This is usually characterized by more redness, more swelling, and more discharge than seen in the recent foreign body or recent trauma. Then it may be treated as such for a few days.

In conclusion, it may be repeated that most physicians, if they so desire, can, with a little practice, very easily diagnose and remove the usual superficial fresh foreign body from the cornea.

References

1. American Encyclopedia of Ophthalmology. Vol. 8, pp. 6168-6169.
2. Berens: The Eye and Its Diseases. Pp. 156, 400, 468. Philadelphia: W. B. Saunders Co., 1936.
3. Duke-Elder: Textbook of Ophthalmology. Vol. 2, pp. 1131-1133. St. Louis: C. V. Mosby Co., 1938.
4. Gifford, S. R.: A Textbook of Ophthalmology. Third ed., pp. 6-7, 169. Philadelphia: W. B. Saunders Co., 1945.
5. May, Charles, H.: Diseases of the Eye. Eighteenth ed., pp. 22-23, 169. Baltimore: William Wood and Co., 1943.
6. Norris and Oliver: System of Diseases of the Eye. Vol. 2, pp. 47-56. Philadelphia: J. B. Lippincott Co., 1900.

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INVERSION OF THE UTERUS

(Continued from Page 1068)

References

1. Das, P.: Inversion of the uterus. Obst. & Gynaec., Brit. Emp., 47:525-548, (Oct.) 1940.
2. DeLee, J. B., and Greenhill, J. P.: The Principles and Practice of Obstetrics. Eighth ed. Philadelphia: W. B. Saunders Co., 1943.
3. Harer, W. B., and Sharkey, J. A.: Acute inversion of puerperal uterus: record of 21 cases. J.A.M.A., 114:2289-2292, (June 8) 1940.
4. Huntington, J. L.; Irving, F. C., and Kellogg, F. S.: Abdominal reposition in acute inversion of puerperal uterus. Am. J. Obst. & Gynec., 15:34-40, 1928.
5. Irving, F. C.: Outline of Abnormal Obstetrics. Boston: E. F. Mahady Co., 1944.
6. McLennan, C. C., and McKelvey, J. L.: Conservative treatment of inversion of the uterus. J.A.M.A., 120:679, (Oct. 31), 1942.
7. Stander, Henricus J.: Williams Obstetrics. Seventh ed. New York: D. Appleton-Century Co.
8. Titus, Paul: The Management of Obstetric Difficulties. Second ed. St. Louis: C. V. Mosby Co.

Detroit Physiological Society

Session of May 15, 1947

The following abstracts are from papers presented at the Tenth Anniversary Meeting of the Society. During the ten years that it has existed, the Detroit Physiological Society has been a medium for the interchange of concepts relating to scientific endeavor in the biological fields. These abstracts represent a summarization of a program which was conducted by founder members of the Society.

Certain Aspects of Thyroid Function

E. A. Sharp, M.D., Department of Clinical Investigation, Parke, Davis and Company, Detroit, Michigan

Diseases of the thyroid gland, as those of any other organ, may result largely from two general pathologic states. First, local inflammatory processes, vascular alteration or new growth may give rise to local symptoms none of which may be related to hormonal function per se. Secondly, pathologic processes involving thyroid function itself and its hormonal state may bring about hyperplasia, hypertrophy and increased secretory activity on one hand or hypoplasia, atrophy or destruction of the gland and decreased secretory activity on the other hand. Generally hyperfunction and hyperplasia go hand in hand. Hypofunction occurs when the gland suffers gross damage from disease or when essential metabolic elements are lacking.

Hyperactivity of the thyroid may result either from increased thyrotopic activity of the anterior pituitary during which state symptomatic evidence of increased output of thyroid hormone generally occurs or from increased demands placed on the gland for augmented supplies of hormones. In the latter case, while the gland is in an apparent hyperfunctional state histologically, symptoms of hyperactivity do not usually appear. Exposure to cold, for instance, induces profound thyroid hyperplasia, although the basal metabolic rate may remain unaltered or even diminished.

Hypofunction may result either from lack of adequate supply of iodine, from withdrawal of pituitary control or from ingestion of chemical substances which interfere with iodine utilization and formation of thyroid hormone. Under such circumstances providing the pituitary is intact, proliferation and hypertrophy of thyroid cells occurs and withdrawal of stored colloid is an early observation of continuous demand for thyroid hormone. Restoration of colloid and return of cellular structure to normal takes place when iodine is supplied or when its utilization by hormonal enzyme systems is resumed.

Administration of iodine in toxic goiter when the gland is hyperplastic and devoid of colloid results in involution of the follicular epithelium and storage of colloid. Thus iodine therapy in both hyperplasia of toxic goiter and hyperplasia of simple goiter of iodine want tend to restore follicular epithelium to normal and to cause restoration of colloid deposition. In simple goiter, lowered basal oxygen consumption is elevated. In toxic goiter, the elevated basal oxidations diminish. Thus, it may be seen that while the histologic effects of iodine in the hypo and hyperactivity states are similar the physiological responses are quite different.

On this occasion the role of iodine in thyroid economy is the basis of discussion. The various hypothyroid states are reviewed with respect not only to iodine requirements and iodine supply but to the many factors which contribute to utilization of this essential element by the thyroid. Many of the practical aspects of iodine therapy are to be presented.

The Metabolism of Iodine

D. A. McGinty, Research Laboratories, Parke, Davis & Co., Detroit, Michigan

The daily iodine requirements of man amounts to 25 to 40 micrograms although the need varies considerably with age, activity and environmental temperature. Of approximately 50 milligrams total iodine in the body, the thyroid contains 20 per cent, this being distributed as thyroxine iodine, 25 per cent, diiodotyrosine iodine, 70 per cent and non-protein-bound, diffusible, ultrafilterable iodine, 5 per cent. Since approximately 300 micro-

grams of thyroxine is secreted by the thyroid daily, large proportions of iodine from degradation of thyroxine in tissues is reutilized by the thyroid.

The great avidity of the thyroid for iodine is accounted for mainly by rapid synthesis of peptide bound thyroglobulin and in part by a loose iodine-protein linkage. Normally circulating iodide is oxidized to iodine within thyroid cells. Iodination of tyrosine is followed by oxidative coupling of diiodotyrosine into thyroxine. These reactions are catalysed by peroxidose and inhibited by antithyroid substances either because of their high reduction potentials, by direct inhibition of enzymatic action of peroxidase or by competition for iodine itself. Secretion and storage of thyroid hormone is controlled by pituitary thyrotropic hormone. An intrafollicular proteolytic enzyme is involved in the transfer of secreted thyroglobulin through follicle cells and in the process of storage of thyroglobulin in the colloid.

Comparative inhibitory effects of certain antithyroid drugs is discussed.

A Background for the Hypometabolic States

Richard E. McKean, M.D.

Though the existence of certain clinical subdivisions of the hypometabolic states has been recognized for some seventy years, the background and scope of this group has been considerably confused. A potential lack of adequate quantities of effective thyroxin may occur from (1) inadequate supply of its precursors, particularly iodine and 1-tyrosine, (2) a disturbed structure of the thyroid gland itself, (3) a functional inability on the part of the gland to synthesize the active hormone or to deliver it to the tissues, and 4() an absence or insufficiency of the necessary stimulus for synthesis of thyroxin, particularly on the part of the thyrotropic hormone of the anterior pituitary.

On this basis a classificaion is offered, dividing the hypometabolic states into (a) those arising from a structural or functional defect within the thyroid gland itself; (b) those arising from without, as an anterior pituitary and other endocrine under functions, and lack of necessary building stones for thyroxin formation; and (c) a diffuse group, such as starvation, fatigue and the like, where a decreased basal metabolism is found but a definite connection with thyroxin deficiency has not been demonstrated.

The Present Status of Iodized Salt

Roy D. McClure, M.D.

The work of Marine and Plummer gave us the scientific background for our belief in the association of iodine lack and thyroid gland enlargement. The work in animal husbandry at the University of Wisconsin and the surveys of school children by Dr. Kimball gave us further information of the importance of iodine.

An iodine deficiency was noted in the water and food in several Michigan localities, and a survey of the incidence of enlarged thyroids in school children in these localities showed that in iodine-deficient areas the incidence of goiter was much greater. In Romeo where the iodine content was extremely low, 75 per cnt of the school children had enlarged thyroids.

In 1924 iodized salt was introduced through the grocery stores without any legislation but with considerable publicity. After a few years the number of goiter operations decreased in our clinic in spite of an increase in the total number of operations. In 1932 a survey of several Michigan hospitals showed a decrease of thyroid operations from 1,060 in 1929 to 715 in 1932, and in a recent survey the number was 510 in 1943. During this time the total number of operations was increasing steadily.

The use of iodized salt has recently been diminishing due to a lack of publicity concerning its necessity, and we fear that this will result in an increase in the incidence of goiter. A bill to change the definition of table salt to include iodine is being introduced in congress this month. We feel that this legislation is the only way to insure the continued use of salt containing a sufficient amount of iodine.

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ON THE RUN . . .

The point of entry into a problem does not necessarily determine its point of emergence.

. . .

Attempts to build up active immunity to histamine have failed because it does not produce antibodies.

. . .

Khellin, a di-methoxy-methyl-furano-chromone, derived from the plant Ammi Visnaga, is capable of active coronary vasodilatation without reduction of blood pressure or increase in pulse rate.

Selected by W. S. Reveno, M.D.

Editorial

SOCIALIZED MEDICINE—POLITICAL MEDICINE

SINCE THE ELECTION last November, and with the new Congress in Washington, we have heard many of our doctors comment: "State Medicine is dead; we don't have to worry any more." That is the sentiment of too many of our members, and is just the attitude our enemies would have us assume. True, the Murray-Wagner-Dingell-Pepper-Truman activity is more or less quiescent, but that is only relative. The authors and principle supporters of this piece of legislation Isadore Falk, Arthur J. Altmeyer, Katherine F. Lenroot, Watson Miller, Thomas Parran, are all in high office in the government, and are not at all hesitant to use the propaganda at their disposal to further "the cause."

But the real danger of government or political medicine is not dead, nor even slightly indisposed. General Paul R. Hawley at Atlantic City told us that any contact with government medicine is dangerous. A small foot in the door is all that is necessary for the program to grow beyond the remotest anticipations.

As an instance of what to expect, on July 16, 1947, Congressman Doliver held hearings before the subcommittee on Health of the House Committee on Interstate and Foreign Commerce on H.R. 1980, introduced by Congressman Howell "to provide for the general welfare by enabling the several states to make more adequate provisions for the health of school children through the development of school health services for the PREVENTION, DIAGNOSIS AND TREATMENT of physical and mental defects." The bill authorizes the appropriation of twelve million dollars for the fiscal year 1947, eighteen million for the fiscal year of 1948, and *such sums as may be necessary* for each succeeding year, of which two million is to be made available to the Children's Bureau to provide (a) demonstrations; (b) training of personnel for State and local health services, through grants to accredited schools of health or other professional institutions; (c) to pay salaries and expenses of personnel detailed at the request of State agencies to co-operate and assist such agencies in carrying out the purposes of this act; (d) to provide the expenses of the Federal Security Agency in the administration of this act.

Here is another attempt to insinuate the government into the practice of medicine. Among those who testified were Major General Louis F. Hershey, Director of Selective Service, with his statement that "thirty per cent of the total number of individuals examined for the draft were physically or mentally or emotionally unable to render the service required of them during World War II;" Maurice Collins, Assistant Director, Federal Security Agency; Katherine F. Lenroot, of the Children's Bureau.

When we think we have stayed the progress of the Political Medicine advocates, we must look for an attack from another source. They are entrenched far stronger than we think, and are just looking for a lapse of our defenses. The Trojan Horse is always around.

ILLEGAL PROPAGANDA

AS THESE EDITORIALS are being prepared, we are in receipt of the First Intermediate Report of the Committee on Expenditures in the Executive Departments. A few quotations are sufficient to cause us to stop and ponder:

"Your committee reports to the House that on the basis of hearings held on May 28 and June 18, 1947, it finds that at least six agencies in the executive branch are using Government funds in an improper manner for propaganda activities supporting compulsory national health insurance, or what certain witnesses and authors of propaganda refer to as socialized medicine, in the United States."

"The departments, bureaus, and agencies known to have participated in this campaign are: 1. The United States Public Health Service; 2. The Children's Bureau; 3. The Office of Education; 4. The United States Employment Service; 5, The Department of Agriculture; and 6, The Bureau of Statistics, Social Security Board."

"Your Committee finds that the use of Federal funds for the purpose of influencing legislation before Congress is unlawful under section 201, title 18, of the United States Code. We have therefore brought these matters to the attention of the Department of Justice, with a request that the Attorney General at once initiate proceedings to stop this unauthorized and illegal expenditure of public monies."

"Our first report deals exclusively with activities calculated to build up an artificial, federally stimulated demand upon Congress for enactment of legislation for compulsory health insurance, referred to by witnesses as the Wagner-Murray-Dingell Bill."

"The extraordinary executive pressure exerted upon the staff of the United States Public Health Service to further the campaign for what certain witnesses and authors of propaganda refer to as socialized medicine is indicated by a letter* sent under date of December 10, 1945 by Thomas Parran, Surgeon General of the United States Public Health Service to all field men and staff operatives throughout the country."

The Surgeon General's letter says:

"The appropriate executive agencies of the Government have been specifically instructed by the President to assist in carrying out this legislative program as presented to Congress on September 6, 1945. . . . Every officer of the Public Health Service will wish to familiarize himself with the President's message and will be guided by its provisions when making any public statement likely to be interpreted as representing the official views of the United States Public Health Service."

The Public Health Department then launched a series of six public health workshops, all the evidence showing that they were planned and financed largely by public officials and funds.

"In preparing for the Jamestown Health Workshop, the Public Health Service distributed in advance to all invited delegates a packet of pamphlets published by the CIO, A.F.of L., the Physicians' Forum (a propaganda agency for the Wagner-Murray-Dingell Bill), and the Government bureaus in support of what certain witnesses and authors of propaganda refer to as socialized medicine. These pamphlets were mailed to the delegates in advance, at Federal expense. They urged that letters be written to Senators and Representatives, advocating immediate action on the Wagner-Murray-Dingell Bill."

"Your committee concludes from the testimony that most, if not all, of this literature, as distributed by the CIO, AFL, The Farmer's Union, and the Physicians' Forum originates in and emanates from the Bureau of Research and Statistics in the Social Security Board. Mr. Isadore Falk is Director of the Division of Research and Statistics in the Social Security Board."

Dr. Herman Hilleboe, Assistant Surgeon General (now New York State Health Commissioner, on loan for one year), testifying before the committee on May 28, 1947, was asked by the chairman whether the literature prepared by the Federal agencies offered all sides of the discussion or was limited merely to supporting material to carry out the President's order. To this question, Dr. Hilleboe answered:

"We would naturally give emphasis to that, because that is why we are in government. Otherwise we would get out of government."

Do you need any further evidence that "something is wrong in Denmark"?

This would all be legalized by H.R. 1980!!!

*This letter was published in full in The Journal, February, 1946, Page 178.

WHAT OF OSTEOPATHY?

WHEN THE MEDICAL Practice act of 1899 went into effect in Michigan, anyone who called himself a Doctor of Medicine, no matter what his schooling, or lack of it, was allowed to register if he was in practice. The quality of our medical schools at the time was deplorable. Only by exposing these conditions and focusing the eye of public opinion on the need was it possible to raise the standards in medicine. The number of schools was reduced by more than half, and the quality of training to which the student was exposed became better and better as the years passed.

A new era of examining the schools as a means of improving the profession had developed, and the American Medical Association has continued that policy, striving toward its goal of the very best of medical service for the people. It now examines medical schools and rates them. Substandard schools can take medical students, but cannot assure them that they can practice in other than a very limited number of states. State Boards of Registration in Medicine do not, as a rule, take such students for licenture examination.

The medical profession has assumed and has claimed that the osteopathic training is not on the same level as our Class A schools. The osteopaths claim they have two or four schools that will meet any standard, and consequently that their graduates are competent for the practice they claim a right to do. We suggest: WHY NOT HAVE AN IMPARTIAL EXAMINATION OF THE OSTEOPATHIC SCHOOLS, the same as was done at the turn of the century with the medical schools? Exposure of deficiencies in medical training raised the standard of medical practice immeasurably. An impartial examination of osteopathic schools would give a base upon which to build for the best health service that can be rendered to our people. If deficiencies are found, they will without doubt be corrected, as was done in medicine.

If the public is to get the best of health service, it will only be through improving the training of young, and older, doctors. A poorly trained doctor does not necessarily have to remain a poor doctor forever. When standards of education are raised, graduates will make every effort for self-advancement. That was demonstrated in medicine. The public, by their choice of doctors, demanded and secured better service.

Postgraduate Courses at University of Michigan Medical School

CLINICAL EXERCISES FOR PRACTITIONERS

Wednesday, October 8, 1947 to May 5, 1948

9:00 A.M.-12:00 NOON—Attendance at surgical ward rounds and surgical operations.
1:30 P.M.- 5:00 P.M.—Surgical Exercises arranged especially for practitioners. These will include clinics, lectures, and demonstration in General Surgery and all of the surgical specialities.
7:45 P.M.- 9:00 P.M.—Surgical staff conference in clinical amphitheater.

The fee is $50. Registration: Room 2040, University Hospital.

CLINICAL INTERNAL MEDICINE

Thursday, October 9 to December 18, 1947; January 8 to April 22, 1948. 1:30 P.M.

Arrangements have been made to meet the demands of practicing physicians for further training in internal medicine by offering a clinical teaching program every Thursday afternoon, beginning October 9 and continuing through December 18, 1947. The schedule will be resumed on January 8 and continued through April 22, 1948. Patients will be presented on ward rounds conducted by two members of the senior staff of the Department of Internal Medicine. The period will end with a conference of the entire medical staff and a review of recent interesting electrocardiograms.

The fee is $50. Limited to 40 members. Registration: 2020 University Hospital.

ELECTROENCEPHALOGRAPHY

In view of the increasing use of electroencephalography as an important diagnostic aid in connection with various focal and non-focal disorders of the central nervous system including brain tumors, epilepsy, encephalitis, and in connection with overlapping psychiatric and neurological manifestations, it has become necessary for general practitioners, neurologists, psychiatrists, pediatricians, internists and neurosurgeons not only to realize when an electroencephalogram is indicated but also to evaluate critically and discriminatingly a detailed electroencephalographic report when it is available.

For this purpose a basic course in electroencephalography will be given for physicians, in the Neuropsychiatric Institute, University Hospital, starting on October 1, 1947. It will consist of 10 consecutive weekly afternoon sessions from 1:30 to 4:30 p.m. The course will cover: history of electroencephalography and electrophysiology, survey of literature, instrumentation, interpretation of graphs, operational techniques, localizing procedures in connection with focal lesions, identification of significant patterns, examination of selected EEG records and demonstration of 3 channel, 6 channel and 8 channel instruments.

Maximum number of registrants: fifteen. Fees for the course: $35.00.

Place of registration: Room 2040 University Hospital, Ann Arbor, Michigan.

Raymond W. Waggoner, M.D.
Director of the Neuropsychiatric Institute

B. K. Bagchi, Ph.D.
In charge of the EEG Course

ALLERGY

Orientation Course in Clinical Allergy

The American Academy of Allergy, under the sponsorship of the University of Michigan Department of Postgraduate Medicine. December 8 to 13, 1947.

A five-day course designed to cover the new and pertinent facts of clinical allergy. The faculty will consist of nationally and internationally known men in the field of allergy, and members of the faculty of the University of Michigan Medical School who are qualified to discuss the inter-relationship of allergy to other fields of medicine. Lectures and case demonstrations will be used to illustrate the problems of diagnosis, and modern management of bronchial asthma, seasonal hay fever, allergic rhinitis, atopic eczema, juvenile eczema, migrainous headaches, gastrointestinal allergy, allergic eye disease, contact and occupational dermatitis, allergic blood dyscrasia, and drug allergy.

Detailed outline of course will be sent upon request.

Registrants: Minimum, 30; maximum, 60. Fee, $40.00.

For Information, write The Registrar
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The first 30 days of life might be called a truly critical period since the greatest number of infant deaths—62.1%—occur during this time. The proportion of infants who die within the first month has, in fact, increased nearly 10% in the past 20 years, while infant mortality on the whole was substantially reduced.*

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*Vital Statistics—Special Reports: Vol. 25, No. 12, National Office of Vital Statistics, Washington, D. C. (Oct. 15) 1946, p. 206.

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Michigan's Department of Health

INCIDENCE OF COMMUNICABLE DISEASE

Disease	*June 1947*	*June 1946*
Diphtheria	29	16
Gonorrhea	758	943
Lobar pneumonia	73	52
Measles	795	1908
Meningococcic meningitis	6	10
Pertussis	807	514
Poliomyelitis	1	4
Scarlet fever	434	418
Syphilis	1189	1437
Tuberculosis	696	418
Typhoid fever	9	4
Undulant fever	32	13
Smallpox	1	0

PROCEDURES TO BE FOLLOWED DURING POLIOMYELITIS EPIDEMICS

1. *Recognition of the Disease.*—Clinically, the diagnosis falls into two categories: *paralytic* and *non-paralytic* poliomyelitis. In addition there is a large and indefinite group of mildly ill patients often designated as suspected, or "abortive" cases. All of these forms may have the same *initial* symptoms, such as fever, acute headache, transient sore throat, gastrointestinal symptoms, nausea and vomiting, and constipation. Clinical evidences of *central nervous system involvement* consist of stiffness of the neck and spine, irritability and hyperesthesia alternating with drowsiness, exaggeration of the muscular reflexes, and, later, local diminution of reflexes and local motor weakness (paralysis). Any of these signs may be absent. Often there are two bouts of fever characterized by the initial symptoms and central nervous system signs in turn. Thus a suspected case often becomes a non-paralytic or a paralytic case.

In the definite paralytic and non-paralytic case, the spinal fluid usually reveals an increased number of cells and elevated protein. These are valuable diagnostic signs. Paralysis may be sudden and cause death within a few hours of onset by cessation of respiration without clear-cut symptoms. There is a marked tendency for the paralysis to improve after it has reached its height.

2. *Etiologic Agent.*—A specific filterable virus.

3. *Source of Infection.*—Virus has been recovered from bowel discharges or throat washings taken from:

(a) persons well or recently convalescent from clinically recognizable paralytic and non-paralytic poliomyelitis;

(b) persons, usually associated with cases of poliomyelitis, who had recently suffered illness not reaching the level of clinical identification.

(c) well persons associated with cases of poliomyelitis, and

(d) other well persons residing in area where virus activity is manifest by an unusual prevalence of the disease.

Virus has also been demonstrated (with difficulty) in tonsils removed at routine tonsillectomy from well persons in a non-epidemic area.

In addition to these human sources virus has been recovered from pools of arthropods, largely consisting of flies trapped in "epidemic areas" and usually from places where such arthropods had easy access to human feces. Virus has also been recovered from sewage. The relative importance to man of these known sources of virus in nature is at present not established.

4. *Mode of Transmission.*—Not definitely known. Circumstantial evidence, however, is more consistent with a hypothesis of transmission through human association than with any other theory yet proposed. Though the virus has been found in flies subject to fecal contamination there is no positive evidence of insects serving as vectors. A few small outbreaks have apparently been traceable to the ingestion of raw milk. Evidence of spread by water supply is lacking.

5. *Incubation Period.*—Considered to be seven to fourteen days, but may be longer.

6. *Period of Communicability.*—Not definitely known. In the *few* tests made prior to the onset of the disease, the virus has been found in oropharyngeal material five days before onset; and from stools nineteen days from onset. In the *many* tests made after onset, virus has been found in the oropharynx for about a week; and in stools up to one to two months.

7. *Susceptibility and Immunity.*—Children are more frequently susceptible than adults, but even during epidemics only 1 person in several hundred suffers a clinical attack of the disease. Second attacks are rare, and might be due to different strains of virus. Older age groups are being more frequently attacked in this country than previously.

8. *Prevalence.*—Infection occurs practically throughout the world, but epidemics are most frequent in the cooler parts of the temperate zones, with the highest incidence in late summer and fall. In the United States an annual incidence of 7 cases per 100,000 population is ordinary. Paralytic cases are more frequent in the temperate zones; the endemic disease may be more widespread in the tropics than statistics indicate.

9. *Methods of Control:*

(A) *Infected Individual, Contacts, and Environment.*

(1) *Recognition of the disease and reporting*: Clinical symptoms assisted by microscopic and chemical examination of the spinal fluid if lumbar puncture is performed.

(2) *Isolation*: Isolation procedures are to be maintained either within the hospital (or at home)

(Continued on Page 1088)

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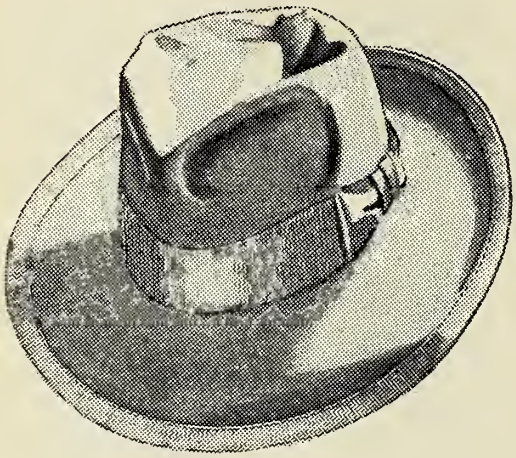

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(Continued from Page 1084)

for a period of 3 weeks from onset of the acute disease.

(3) *Concurrent disinfection*: Pharyngeal secretions and bowel discharges are infectious and should be disposed of as quickly and safely as possible. Containers and other contaminated articles should be sterilized.

(4) *Terminal disinfection*: None.

(5) *Quarantine*: None.

(6) *Active immunization*: None.
Passive immunization: Not recommended.

(7) *Investigation of source of infection*: Search for and employ expert diagnosis of sick children to locate unrecognized and unreported cases of the disease.
Regard open sewage or human feces as a possible source of infection for flies; obvious contamination of vegetables resulting from irrigation with human sewage to be avoided.

(B) *General Measures During Epidemics.*

(1) General warning to physicians and the laity of the prevalence or increase of incidence of the disease. It is highly advisable for health officers to confer with local physicians *early* in the epidemic with regard to a plan for action, rather than a cause for panic with particular attention to:
(a) Criteria for *diagnosis* and *reporting* paralytic and non-paralytic cases.
(b) Criteria for hospitalization.
(c) Organization for *concerted* action, and control of publicity.

(2) Importance of warning physicians that during epidemic times all cases of *unexplained fever* in children be regarded with extra care and treated cautiously with at least one week of bed rest.

(3) Protection of children so far as practicable against unnecessary contact with other persons, especially those outside their own homes, during epidemic prevalence of the disease.

(4) It is axiomatic that removal of human excrement from potential intimate contact with human populations is a desirable and essential public health objective on all scores and at all times. Emergency alterations in community collection and disposal of human excreta, however, are not believed to be practicable for controlling a current epidemic of poliomyelitis.

(5) To avoid contamination of food by flies is part of any public health program in which there is even a remote possibility that flies may act as vectors. Fly control is therefore recommended for cleanliness' sake but not with a view that any known fly abatement procedure will control an epidemic.

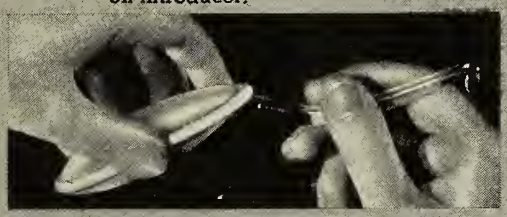
(6) Postponement of nose, throat and dental operations or any form of elective surgery in the presence of an epidemic.

(Continued on Page 1090)

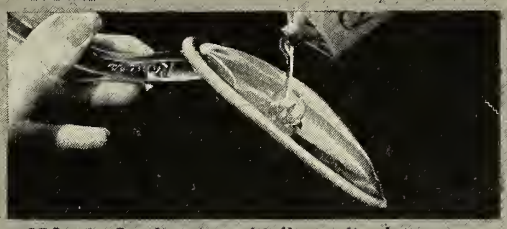
Say you saw it in the Journal of the Michigan State Medical Society

Designed to Assist the Patient

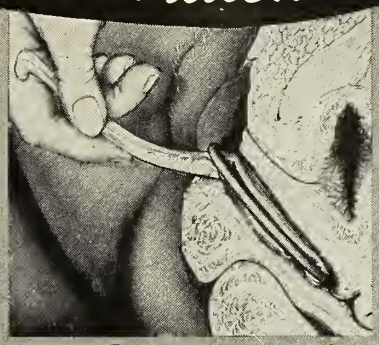
NO. 1 Beginning placement of diaphragm on introducer.



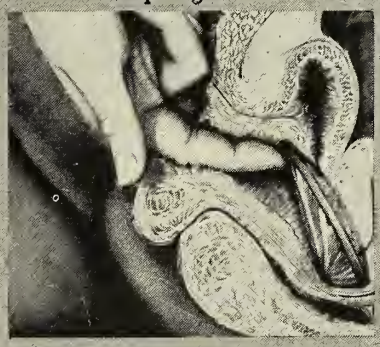
NO. 2 Diaphragm placed on introducer.



NO. 3 Application of jelly to diaphragm.



NO. 4 Beginning insertion of diaphragm.



NO. 5 Placement of diaphragm.

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(Continued from Page 1088)

(7) Avoid unnecessary travel and visiting during epidemic times, particularly by children either to or from the epidemic area. Closing of State borders as a quarantine measure is not recommended.

NOTE: The above contribution was prepared by a group of physicians at a Round Table Conference held at Yale University in January, 1947. The group consisted of: Gaylord W. Anderson, Mayo Professor and Director, School of Public Health, University of Minnesota, Minneapolis; Charles Armstrong, Chief, Division of Infectious Diseases, Federal Security Agency, U. S. Public Health Service, National Institute of Health, Bethesda, Maryland; Thomas Francis, Jr., Distinguished Professor of Epidemiology, School of Public Health, University of Michigan, Ann Arbor; Gordon C. Brown, Associate Professor of Bacteriology, School of Public Health, University of Michigan, Ann Arbor; Charles A. Evans, Professor of Bacteriology, College of Medicine, University of Washington, Seattle; A. G. Gilliam, Senior Surgeon, U. S. Public Health Service—Assigned to School of Public Health, University of Michigan, Ann Arbor; D. M. Horstman, Instructor in Preventive Medicine, Section of Preventive Medicine, Yale University, New Haven; Howard A. Howe, Professor of Preventive Medicine, School of Public Health and Hygiene, The Johns Hopkins University, Baltimore; Kenneth F. Maxcy, Professor of Epidemiology, School of Public Health and Hygiene, The Johns Hopkins University, Baltimore; Joseph L. Melnick, Research Associate, School of Medicine, Yale University, New Haven; John R. Paul, Professor of Preventive Medicine, School of Medicine, Yale University, New Haven; Thomas M. Rivers, Director, The Hospital of the Rockefeller Institute for Medical Research, New York; Albert B. Sabin, Professor of Research Pediatrics, Children's Hospital Research Foundation, University of Cincinnati, Cincinnati; Robert Ward, Associate Professor of Pediatrics, College of Medicine, New York University, New York.

Communication

A. A. Drolett, M.D., Chairman
Legislative Committee, MSMS

Dear Dr. Drolett:

On behalf of the Oakland County Medical Society, I would like to express our sincere appreciation of the fine record established by the Legislative Committee during the last session of the Michigan Legislature.

It is gratifying to know that the Michigan State Medical Society is on the job to handle matters of this nature, and especially, that there are such capable persons willing to give unselfishly, the great amount of time that must be necessary to keep abreast of the happenings in our Legislature.

The work that has been accomplished is of inestimable value to every Michigan physician and it is therefore, a great pleasure for me to extend the heartfelt congratulations and thanks of the Oakland County Medical Society to you and your committee for a tremendous job especially well done.

Respectfully yours,

O. R. MacKenzie, M.D.,
Secretary

July 23, 1947.

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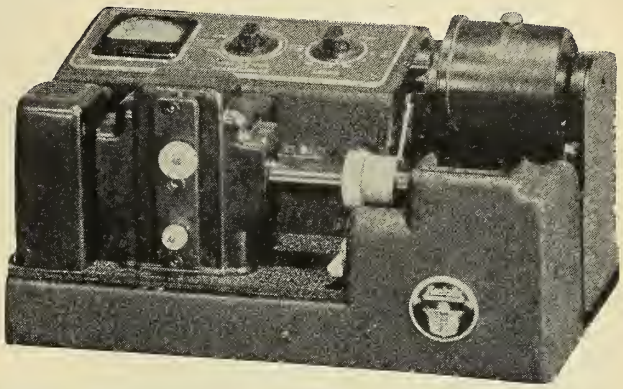

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In Memoriam

Roy C. Perkins, M.D., Bay City, was born in Harbor Beach in 1878 and was graduated from the University of Michigan School of Medicine in 1903. He practiced for one year in Harbor Beach and then came to Bay City.

Doctor Perkins had a long military record, having been a member of the National Guard medical corps from 1910. He served as commanding officer of the Second Ambulance Company at El Paso in 1916-17 in the Mexican conflict. He entered World War I service on June 15, 1917 and served overseas with the 128th Field Hospital, 107th Sanitary Train, 32nd Division. Doctor Perkins had served as a member of the local School Board, City Board of Health, the State Advisory Council of Health, Councilor of the Michigan State Medical Society, and President of the Bay County Medical Society. Doctor Perkins died in Bay City on June 18, 1947.

* * *

Alfred L. Arnold, Sr., M.D., Owosso, was born in 1858. Graduated from the Detroit College of Medicine, 1886. Practiced medicine in the Owosso area his entire lifetime. Served as mayor of Owosso at one time; elected Emeritus Member of Michigan State Medical Society 1937. Alfred L. Arnold, Jr., M.D., Owosso, survives. Doctor Arnold died at his home, April 18, 1947.

* * *

Howell L. Begle, M.D., Detroit, was born in 1877 and was graduated from the University of Michigan School of Medicine in 1905. Dr. Begle was a native of Saginaw, Michigan, attended West Point Military Academy. Doctor Begle died in Detroit on June 5, 1947.

* * *

Peter F. Carlucci, M.D., Detroit, was born in 1888 and was graduated from the University of Pennsylvania Medical School in 1907. He began the practice of medicine in Scranton, Pennsylvania and later came to Detroit where he continued his practice until the time of his death on May 14, 1947.

* * *

Clarence V. Costello, M.D., Holland, was born in 1886 and was graduated from the University of Buffalo School of Medicine in 1911. He served as a medical officer during World War I and practiced for thirty

(Continued on Page 1094)

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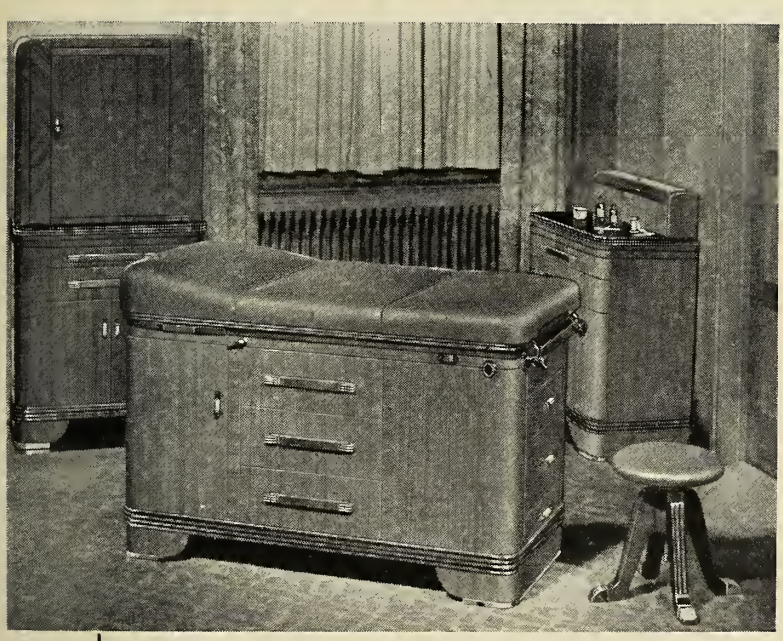

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(Continued from Page 1092)

years in Rochester, N. Y., before coming to Holland. Dr. Costello died in California on May 31, 1947, following a prolonged illness.

* * *

John D. Donovan, M.D., Dearborn, was born in Grand Forks, N. D., in 1911. He was graduated from St. Louis Medical School, 1935. He was industrial physician with the Ford Motor Company at the time of his death, which occurred April 19, 1947.

* * *

Samuel A. Flaherty, M.D., Detroit, was born in 1886. He was graduated from the Detroit College of Medicine and Surgery in 1914. He served with the Canadian Army in World War I and has practiced in Detroit since that time. Doctor Flaherty died on May 8, 1947 while en route to North Carolina.

* * *

Alpheus T. Hafford, M.D., Albion, was born at Manistique, Michigan, in 1889, the son of the late George C. Hafford, M.D. He was graduated from the University of Michigan Medical School in 1913 and practiced continuously in Albion. Doctor Hafford died suddenly April 23, 1947.

* * *

Levi A. Harris, M.D., Gaylord, was born in Utica, Michigan, in 1858, and was graduated from the Detroit Medical College in 1884. Doctor Harris had practiced medicine in the northeastern part of Michigan for well over fifty years. He was made an Emeritus Member of the Michigan State Medical Society in 1937. Doctor Harris died in Grayling on June 25, 1947.

* * *

William Hipp, M.D., Detroit, was born in 1878. He was graduated from the Detroit College of Medicine in 1906 and had practiced in Detroit since that time. Doctor Hipp died at his home on May 3, 1947.

* * *

Francis A. Jones, Sr., M.D., Lansing, was born in 1874, and was graduated from the University of Michigan School of Medicine in 1903. He practiced in Potterville and for the past thirty-five years in Lansing. He is the father of Francis A. Jones, Jr., M.D., of Lansing. Doctor Jones died in Lansing on July 5, 1947, following a year-long illness.

* * *

William H. Lake, M.D., Jackson, was born in Dowagiac in 1885 and was graduated from the Northwestern University Medical School in 1910. He had practiced in Grass Lake and for the past twenty-five years in Jackson. Doctor Lake died suddenly at his summer home on June 25, 1947.

* * *

Holton M. Lowe, M.D., Battle Creek, was born in 1876 near Norwalk, Ohio, and was graduated from the University of Michigan Medical School in 1916, after having taught school and having graduated from Ohio Wesleyan University where he prepared for the ministry. Doctor Lowe was the father of two other Battle Creek doctors of medicine, Drs. Stanley T. Lowe and Kenneth H. Lowe. Doctor Lowe died in Battle Creek on June 21, 1947.

Say you saw it in the Journal of the Michigan State Medical Society

James A. Rowley, M.D., Flint, was born in Orland, Indiana, in 1875, and was graduated from the University of Michigan Medical School in 1903. He had practiced in Flint for the past twenty-five years. Doctor Rowley died in Flint on June 22, 1947.

* * *

Joseph E. Wellman, M.D., Port Huron, was born in Port Huron in 1877. He was graduated from the Detroit College of Medicine in 1905 and following completion of his internship at Harper Hospital, Detroit, came to Port Huron to practice. Doctor Wellman died on May 8, 1947 after an illness of three weeks.

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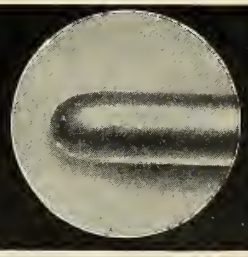

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What's What

Arthur C. Curtis, M.D., Ann Arbor, is co-author of an article on "Histoplasmosis" which appeared in JAMA of August 9.

* * *

E. S. Gurdjian, M.D. and J. E. Webster, M.D. of Detroit are authors of "Injuries of the Head" which also appears in JAMA of July 26.

* * *

W. H. Beierwaltes, M.D. and F. X. Byron, M.D. of Ann Arbor are authors of an original article "Arteriovenous Aneurysm" which appeared in JAMA of July 26.

* * *

Michigan is expecting the largest wheat crop since 1898, according to J. C. Swanson of the Michigan Agricultural Department.

* * *

The state sales tax, for the fiscal year ending June 30, 1947, amounted to $156,995, 460. This was the mainstay of the state collections of $185,045,086.

* * *

The Arizona State Medical Association has raised its annual dues from $30 to $50 for 1948. The California Medical Association's dues are $60 per annum.

* * *

Rural Doctors—The Indiana State Medical Association has raised $10,000 for establishing Medical Scholarships for five prospective doctors who will practice in rural areas.

* * *

The American Association for the Study of Goiter will holds its annual meeting in the King Edward Hotel, Toronto, Canada, May 6-7-8, 1948.

* * *

The Sixth International Assembly of the International College of Surgeons is scheduled for Rome, Italy, May 18-21, 1948. Headquarters will be the University of Rome Polyclinic.

* * *

B. C. Hall, M.D. of Pompeii was honored on July 6 by members of the Gratiot-Isabella-Clare County Medical Society and by the citizens of Alma on the occasion of his fiftieth anniversary in the practice of medicine.

* * *

Dr. G. H. A. Clowes of Indianapolis was awarded the Banting Medal by the American Diabetic Association at its June meeting in Atlantic City. Dr. Clowes is Director Emeritus of the Lilly Research Laboratories.

* * *

Fifty Years Club.—The Illinois State Medical Association has formed a "Fifty Years Club" as an honor to members who have attained fifty years in practice.

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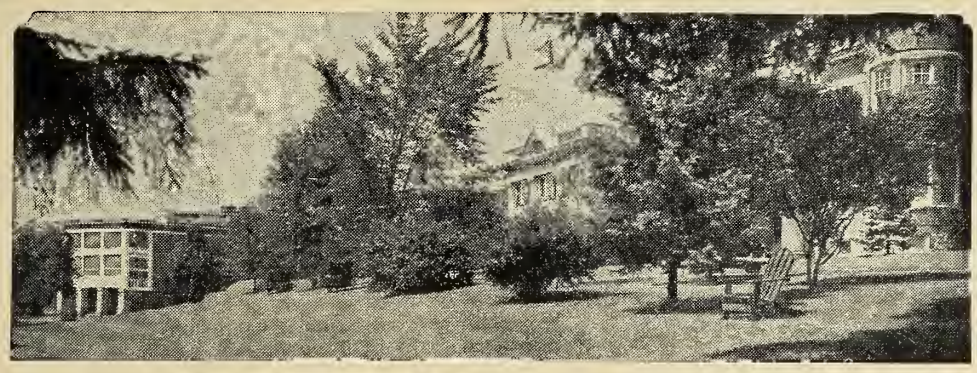

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There is a meeting each year, and members are given a certificate and a gold emblem. There are now 509 members, and the club is quite popular.

* * *

Action taken by the AMA House of Delegates in Atlantic City will result in the promotion of Health Councils in states, counties and cities. This action was recommended by the Conference of Presidents in December, 1945.

* * *

Holy Cross Hospital, Detroit, held its first annual golf tournament at Lochmoor Golf and Country Club on July 23. William J. Yott, M.D., won the Chief of Staff Trophy for low gross. Runners up were William R. Flora, M.D. and Henry J. Kehoe, M.D.

* * *

Officers of the Conference of Presidents of State Medical Associations are: L. H. Schriever, M.D., Cincinnati, Ohio, President; J. H. Howard, M.D., Bridgeport, Connecticut, President-elect; John Hunton, San Francisco, California, Secretary-Treasurer.

* * *

Salt.—The U. S. production of salt is about 40 per cent of the world total, two-thirds of the evaporated and rock salt coming from three states—Michigan, New York, and Ohio. The more civilization has progressed, the more demand there has been for salt.

* * *

One of every thirty veterans in school under the GI Bill is studying medicine or related subjects, according to the Veterans Administration. Out of a total of 1,825,000 veterans in schools, colleges, and universities as of May 1, 1947, the survey showed 59,360 enrolled in all phases of medical training.

* * *

Ernest R. Gibson, Public Relations Counsel of the Florida Medical Association, with headquarters in Jacksonville, visited the Executive Offices of the Michigan State Medical Society on July 24, to survey the public relations work being done by the Michigan State Medical Society.

* * *

M. William Clift, M.D., Flint, was honored with a testimonial dinner by the Genesee County Medical Society on June 18. Dr. Clift who has been radiologist at Hurley Hospital since 1932, and Flint's first radiologist, resigned to become radiologist at Midland Hospital, Midland, Michigan as of July 1, 1947.

Wayne University College of Medicine announces a postgraduate continuation course in electrocardiography to be given at Receiving Hospital Thursday afternoon from 4:00 to 5:00 p.m., for 24 weeks —October 2, 1947, through April 1, 1948. Fee, $30.00. For registration blank and further information, contact Dr. Arthur H. Smith, Director, Graduate Medical Education, Wayne University College of Medicine, 1512 St. Antoine, Detroit 26, Mich.

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Attention Medical Officers.—One copy of the "Analysis of the Postwar Questionnaire," published by the American Medical Association, is available to every discharged medical officer, upon request. Write F. G. Dickinson, AMA, 535 N. Dearborn St., Chicago 10, Illinois.

* * *

State appropriations of interest to the medical profession include the following items (for fiscal year beginning July 1, 1947):

Public Health—$8,530,355.
Mental Hygiene—$20,316,083.
Public Welfare—$42,643,793.
Veterans Benefit Trust—$638,000.

* * *

John S. Knight in the *Detroit Free Press* of Sunday, June 8, 1947, writes as follows:

"Governments can make men very lazy. They can stifle individual enterprise . . . Come to Europe and take a look.

"The evidence is clear, state medicine and high taxes combined with compulsory health services, can and are making physicians lazy. They can and are depriving the community of capable medical services."

* * *

New Compulsory Health Insurance Bill S. 1320 was introduced by Senator Murray for himself and Senators Robert A. Wagner, of New York, T. Howard McGrath of Rhode Island, Glenn H. Taylor of Idaho, and Dennis Chaves of New Mexico. We can evidently no longer call it the Wagner-Murray-Dingell bill. So far it has not been named.

* * *

International College of Surgeons.—The Twelfth National Assembly of the International College of Surgery will convene at the Palmer House, Chicago, September 28 to October 4, 1947. Information and programs may be obtained from Louis J. Gariepy, M.D., of Detroit, Secretary of the United States Chapter. Mr. William J. Burnes is Director of Exhibits through the courtesy of the Michigan State Medical Society.

* * *

J. K. Pollack of the University of Michigan has been selected by the President of the United States Senate as a member of a newly formed commission authorized under recently enacted Senate Bill 164 and H.R. 775 to streamline the executive department of the government.

The necessity for a study such as the Commission is charged to make is demonstrated in the following paragraph taken from the Senate's report of the bill:

* * *

Veterans Administration is sponsoring a huge exhibit of prosthetic devices at its headquarters in Washington, D. C. The exhibit comprises 1,000 items and includes, legs, arms, hands, hearing aids, illuminated canes, telescopic crutches—every type of prosthesis except dentures and eye glasses—the most complete display of its kind in the world. The medical profession is invited to inspect this permanent display.

* * *

The American College of Physicians announces that a limited number of Fellowships in Medicine will be available beginning July 1, 1948, for one year. The

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stipend will be from $2,200 to $3,000. For full information and application forms, write the ACP, 4200 Pine St., Philadelphia 4, Pa., before November 1, 1947.

The ACP will conduct its 1948 Annual Session in San Francisco, April 19 to 23.

* * *

F. G. Buesser, M.D., Detroit, was signally honored by the Medical Faculty of Wayne University College of Medicine through the presentation of a life size portrait of Dr. Buesser by Roy Gamble, famous portrait painter. The likeness of Dr. Buesser now hangs in the Wayne University Medical School.

* * *

L. Fernald Foster, M.D., Bay City, MSMS Secretary, was dinner speaker at the Sixth Annual Upper Peninsula meeting held by the Michigan Society for Crippled Children and Disabled Adults at Marquette on Monday, August 11. Dr. Foster outlined "The Michigan Rheumatic Fever and Cardiac Program."

M. Cooperstock, M.D. of Marquette addressed the same meeting on "Medical and Social Aspects of Rheumatic Fever."

* * *

MSMS has appointed a Committee to study the medical and hospital facilities of Jackson Prison, on invitation of W. H. Burke, Assistant Director, Bureau of Prisons. The study will be made by a joint committee representing the Michigan State Medical Society, the Michigan Hospital Association, and the Michigan Department of Health.

Philip A. Riley, M.D., Jackson and O. O. Beck, M.D., Birmingham, are the members of the committee representing MSMS.

* * *

The Michigan Hospital Survey and Construction Act was signed by Governor Sigler on June 30, 1947 and became Act No. 299 of the Public Acts of 1947.

Next on the agenda is the selection of a state director, appointment of a Michigan hospital advisory council, and development of a state plan of hospital construction for Michigan. Properly supervised and conducted, this program should promote better hospital service in this state.

* * *

ILO objects to free choice. The International Labor Organization (of which the United States became a member in 1934) has this to say about the free choice of physician by patient:

"The right of the patient to chose his doctor in each case of illness, according to what appears to him most appropriate or desirable, is . . . no longer compatible with the modern approach to the health problem."

Also, the ILO proposes a basic salary augmented by capitation fees, or, alternately, a full time salary, under its socialistic program of state medicine.

* * *

The State-Federal programs under Vocational Rehabilitation have rehabilitated 160,000 adult civilians and placed

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them in paying jobs since July, 1943, according to OVR Director M. J. Shortley who estimates that this country today has 1,500,000 men and women with physical or mental handicaps, 15 per cent of whom require vocational rehabilitation services annually.

Under the State-Federal programs, patients who cannot pay receive free physical, medical, surgical and psychiatric and hospital care to reduce or remove the deficiency. Prosthetic devices also are available on the same basis, to those unable to pay.

* * *

Veterans Home-Town Medical Care Program—In November, a meeting will be called in Chicago of state medical society representatives to discuss this program with the AMA and with Veterans Administration officials.

This meeting will be called in view of recent changes in the policy of the Veterans Administration re the home-town medical care program. This follows a recommendation made by the AMA Council on Medical Service adopted by the 1947 House of Delegates in Atlantic City. It is hoped that the meeting will effect solution of existing problems.

* * *

Surgery Gynecology and Obstetrics for August, 1947 contained four papers by Michigan authors:

Pulmonary Resection for Solitary Metastatic Sarcomas and Carcinomas—John Alexander, M.D., F.A.C.S., and Cameron Haight, M.D., F.A.C.S., Ann Arbor.

Improvement in Abdominal Hysterectomy Mortality—Roger S. Siddall, M.D., F.A.C.S., and Harold C. Mack, M.D., F.A.C.S., Detroit.

The Mechanism of Production of Linear Skull Fracture; Further Studies on Deformation of the Skull by the "Stresscoat" Technique—E. S. Gurdjian, M.D., F.A.C.S., H. R. Lissner, M.S., and J. E. Webster, M.D., Detroit.

The Stability of Thrombin, Penicillin, or Streptomycin, in the Presence of Gelatin Sponge, Oxidized Cellulose or Each Other—John T. Correll, Ph.D., and E. C. Wise, M.S., Kalamazoo.

* * *

The Cover

The Ohio State Legislature, which adjourned in June 1947, appropriated $8,000,000 to the Board of Trustees of Ohio State University to build a new 600-bed University Hospital, and a new Dental Clinic. Also appropriated was $2,000,000 to the State Department of Health for the construction of a 300-bed Tuberculosis Hospital unit, to be planned and built as an integral part of the University Medical Center; and $1,250,000 was appropriated to the Department of Public Welfare, for the construction of a 200-bed Neuropsychiatric Receiving Hospital for diagnosis, therapy and research, in direct physical association with the University Hospital. These latter two auxiliary units will be separate units, but with direct physical connection with the University Hospital, and will extend westward toward the river, from the west end of the new thirteen-story University Hospital.

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The Michigan State Board of Registration in Medicine, on July 29, 1947, gave public notice that it had reinstated the Michigan medical licensure of Edward Harry Thomas, M.D., Fred William Thomas, M.D., and Donald A. Cowan, M.D. Also that it had suspended for a period of three years the license of John Windiate Warren, M.D. of Detroit.

Raymond Moley speaks on "Subsidized Medicine."

"In the current 'Kiplinger Magazine,' a point is made about the glaring difference in the results of two polls on health insurance. One poll asked people if they would approve a 6 per cent deduction from wages for federal medical care and hospitalization. Only 16 per cent of the replies were favorable. Another poll asked if they approved of helping social security cover doctor and hospital care. Sixty-eight per cent approved.

"This is about the way people react to the subject. If they are asked to pay for having the government do something, they say no. If the inference is conveyed that they will get something for nothing, they are for it."
—*Chicago Journal of Commerce,* July 9, 1947.

* * *

Needed! More Members of Congress to Study National Social Insurance Schemes. It becomes increasingly clear that more members of Congress should be informed about the history and the implications of national social insurance. Too long have members of the Social Security staff lorded it over Congress. Too long have Government "experts" told Senators and Representatives cock and bull stories about social security programs. The time is long overdue for members of Congress to be in a position to back some of the "experts" off the map. Too long has the Social Security crowd dominated the scene. They have written designedly incomprehensible and intentionally devious bills, replete with double-talk, weasel words, and hidden meanings. Congress is not supposed to know what is in the bills, and does not know. The W-M-D bills are perfect illustrations of bureaucratic obfuscation masquerading as pieces of sane legislation. Neither S. 1320 nor the publicity regarding it conveys the slightest idea about what the legislation would do to this Government and to the American people. Fortunately, some members of Congress are studying these very questions.—American Medicine and the Political Scene, August 6, 1947.

* * *

"During the past sixteen years, national and international events have necessitated a constantly expanding emergency government. In the wake of the prolonged economic distress of the 1930's and the 4 years of direct participation in World War II, the number of principal components of the Federal Government have multiplied from 521, in 1932, to 2,369, in 1947. The annual pay roll of the executive branch of the Government today approximates 6¼ billion dollars which is 1½ billion dollars more than the Government spent for all purposes in 1933. The executive branch now employs more people than all the state, city, and county governments combined.

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of governmental operation. For example, there are no less than twenty-nine agencies lending Government funds, thirty-four engaged in the acquisition of land, sixteen engaged in wildlife preservation, ten in Government construction, nine in credit and finance, twelve in home and community planning, ten in materials and construction, twenty-eight in welfare matters, four in bank examinations, fourteen in forestry matters, and sixty-five in gathering statistics. Excluding the Army and the Navy, there are more Federal employes in the payroll today than on V-J day. And all the evidence points towards still further expansion, aimlessly, pointlessly, pleasing no one and frustrating sincere efforts to serve the people. The cessation of hostilities has brought little reduction in the tremendous war expansion of the Government."

* * *

Statistics of Navy Medicine published monthly by the Bureau of Medicine and Surgery for intra-service use, contains interesting reports, in the current issue, on acute appendicitis, inguinal hernia, fungus infections and mumps.

Acute appendicitis—Between 1936 and 1945, inclusive, there were 96,670 cases in the Navy and Marine Corps, an average annual incidence rate of 873.7 per 100,000 strength. Sick days totaled 2,004,729, an average of slightly over 20 per case. Death occurred in 288 (0.3 per cent) of the cases.

Inguinal hernia—During the war years (1942-45), 53,605 cases were reported, which gave this disease an incidence rank of 17th. It ranked seventh, however, as a producer of sick days, being responsible for 2,121,500 over the four-year period.

Fungus infections—From a low point of 404.3 cases per 100,000 strength in 1942, fungus infections of the skin rose to a high of 625.4 in 1944. The diagnosis ranked 16th in incidence of all diseases and 16th in sick-day importance. Foot infections accounted for more than one-half of all cases.

Mumps—Incidence of mumps in March of this year was less than half the rate of 11.4 per 1,000 strength that was recorded in March, 1946, a peak figure for the two-year period ended in April, 1947. The report shows that the greatest proportion of mumps cases, within the United States, originates in the 5th, 9th and 11th Naval Districts, where the largest training stations are situated.

* * *

Michigan Rural Health Conference of September 18-19 a Great Success.—A total of 472 representatives of twenty-eight organizations interested in rural health registered at Michigan State College, East Lansing, on September 18 and 19 at the First Annual Michigan Rural Health Conference, sponsored by the Michigan State Medical Society.

H. B. Zemmer, M.D., Lapeer, chairman of the Michigan Mental Health Commission and of the MSMS Rural Health Committee, introduced the afternoon speakers of September 18: Dr. E. L. Anthony, East Lansing, Dean, College of Agriculture, Michigan State College, who delivered the address of welcome; Emory W. Morris, D.D.S., Battle Creek, President, W. K. Kellog Foundation, who spoke on "Hospital Facilities and Health Centers;" A. C. Furstenberg, M.D., Ann Arbor, Dean, University of Michigan Medical School, who presented his plan of "Bringing and Holding Physicians in Rural

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Areas;" L. Fernald Foster, M.D., Bay City, Secretary, MSMS, who outlined a plan of "Financing Personal Health"; and Miss Marian Murphy, R.N., Ann Arbor, Assistant-Director, Public Health Nursing Division, School of Public Health, University of Michigan, who discussed "Nursing and Ancillary Needs of Rural Communities."

Governor Kim Sigler spoke at the evening meeting in the Fairchild Theater of Michigan State College on "Your Future is Healthier in Michigan."

Louis Bromfield, author and lecturer, spoke on "The Relation of Good Soil, Good Agriculture and a Sound Economy to the Health and Well Being of Rural Communities." The evening meeting was chairmanned by Wm. A. Hyland, M.D., Grand Rapids, MSMS President.

Friday morning's session heard R. H. Pino, M.D., Detroit, Chairman of the MSMS Commission on Health Care, present a unique program of "Medical Associates;" Charles P. Loomis, Ph.D., East Lansing, Head of Department of Sociology and Anthropology, Michigan State College, gave an interesting talk on "Measuring Rural Medical Needs;" J. S. DeTar, M.D., Milan, Speaker of the House of Delegates, MSMS proposed "A Plan for Rural Health Service."

Graham Davis, Battle Creek, R. I. Novy, M.D., and E. R. Witwer, M.D., Detroit, and Hulda Edman, R.N., Lansing, presented reports on the Friday afternoon Section meetings, and Hardy A. Kemp, M.D., Detroit, Dean, Wayne University College of Medicine, closed the Conference with a summary of the first annual Michigan Rural Health Conference.

Co-sponsors of the Michigan Rural Health Conference were: Michigan State College, Michigan Education Association, Michigan Foundation for Medical and Health Education, Michigan State Grange, Michigan Farm Bureau, Michigan State Social Welfare Commission, Wayne University College of Medicine, Michigan Department of Health, Ingham County Medical Society, Michigan Medical Service, Michigan State Nurses Association, Michigan Tuberculosis Association, Michigan Hospital Service, W. K. Kellogg Foundation, Michigan State Pharmaceutical Association, MSMS Women's Auxiliary, Michigan Hospital Association, Michigan Society for Crippled Children and Disabled Adults, American Cancer Society, Michigan Division, Michigan Crippled Children's Commission, Michigan Farmer, Michigan Junior Farm Bureau, Michigan Health Council, Michigan Rural Teachers Association, Children's Fund of Michigan, Michigan Congress of Parents and Teachers, and the Michigan Mental Health Commission.

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Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

THE 1946 YEAR BOOK OF ENDOCRINOLOGY, METABOLISM AND NUTRITION. *Endocrinology*, by Willard O. Thompson, M.D., Clinical Professor of Medicine, University of Illinois College of Medicine; Attending Physician (Senior Staff), Henrotin Hospital; Attending Physician, Grant Hospital of Chicago: *Metabolism and Nutrition*, by Tom D. Spies, M.D., Associate Professor of Medicine, University of Cincinnati School of Medicine; Director, Nutrition Clinic, Hillman Hospital, Birmingham, Alabama. Chicago: The Year Book Publishers, 1947. Price $3.75.

Endocrinology as a book title is new, this edition in the past having been an appendage to Neurology and Psychiatry. The subject has grown up and, with its natural neighbor Metabolism and Nutrition, makes a first class book. The best information in the articles dealing with the subjects, published during the year 1946, are abstracted making up the text of this book, following the plan of the other Year book. There is an index of subjects and authors.

A TEXTBOOK OF MEDICINE, Edited by Russell L. Cecil, A.B., M.D., Sc.D., Professor of Clinical Medicine, Cornell University Medical College; Consulting Physician, New York and Veterans' Hospitals; Visiting Physician, Bellevue Hospital, New York City. With assistance of Walsh McDermott, M.D., Associate Professor of Medicine, Cornell University Medical College. Associate Editor for Disease of the Nervous System: Harold G. Wolfe, M.D., Associate Professor of Neurology, Cornell University Medical College. Seventh Edition. 1730 pages, with 244 illustrations. Philadelphia and London: W. B. Saunders Co., 1947. Price $10.00.

This textbook of medicine is a compilation of articles by over 160 contributors. It is a complete text in every detail, has sixteen new articles on such topics as Blackwater Fever, Drug Allergy, Marijuana Intoxication, Acrodynia, Vitamine Deficiencies, A, E, K and Hypervitaminosis, the Hemoglobinurias, Diphtheritic Polyneuritis, Headache, Psychosomatic Medicine, et cetera.

New authors have rewritten over fifty aritcles, on account of death of the previous contributor. Each article is complete in itself and is authoritative, giving the clinician sufficient information for successful diagnosis and treatment.

CONCISE ANATOMY. By Linden F. Edwards, Ph.D., Professor of Anatomy, The Ohio State University, Columbus, Ohio. 324 Illustrations. Philadelphia: The Blakiston Co., 147. Price $5.50.

Professor Edwards found the texts on anatomy not suitable for his needs in teaching students of ancillary groups, especially, physical education. He therefore wrote his own text, using standard authorities but rearranging the sequence of presentation and giving especial attention to the bone, muscle articulations, blood vessels and nerves in each region of the body as they are studied.

Diagnosis and treatment of the usual types of athletic injuries are presented with the idea that these will be the most valuable and interesting to the group of students most likely to use the text. It is well illustrated and concisely written, a good text for any teacher or group needing a good working knowledge of human anatomy.

(Continued on Page 1106)

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(Continued from Page 1104)

A MANUAL OF THE COMMON CONTAGIOUS DISEASES. By Philip Moen Stimson, A.B., M.D. Assistant Professor of Clinical Pediatrics, Cornell University Medical College; Visiting Physician, Willard Parker Hospital; Director, Poliomyelitis Service, The Knickerbocker Hospital; Medical Director, The Floating Hospital of St. John's Guild, etc. Fourth edition, thoroughly revised. 12 mo, 503 pages. with 67 illustrations and 8 plates, 6 in color. Philadelphia: Lea & Febiger, 1947. Flexible binding; $4.00.

This manual is boiled down to essentials, each article being concise, clear and suitable to the student of medicine, interested in public health and hygiene.

There are some invaluable colored pictures for diagnosis and to familarize the practitioners with various diseases where exact diagnosis is essential.

Tables of incubation periods, percentages of mortality and treatment are all given.

Many references are available for further study.

A HISTORY OF THE AMERICAN MEDICAL ASSOCIATION, 1847-1947. By Morris Fishbein, M.D., with the Biographies of the Presidents of the Association by Walter L. Bierring, M.D., and with Histories of the Publications, Councils, Bureaus, and Other Official Bodies. 1226 pages. Philadelphia and London: W. B. Saunders Company, 1947. Price $10.00

Fishbein's History of the American Medical Association celebrates the one hundredth Anniversary in a most fitting manner. This book could not have had a better qualified author, Dr. Fishbein having lived the American Medical Association since he became assistant editor in 1917. He became editor in 1924 and has had every opportunity to know the American Medical Association. The book is a general history showing organization and growth, the formation of Judicial and other Councils, and sketches of leaders of the medical profession who have been presidents of the Association. The book is delightful reading, and stimulating to enthusiasm for our profession. The general public, as well as the physician, will recall the long struggle for higher standards of education and practice and the continuing fight against quackery.

GYNECOLOGY WITH A SECTION ON FEMALE UROLOGY. By Lawrence R. Wharton, Ph.B., M.D., Assistant Professor of Gynecology, The Johns Hopkins Medical School; Assistant Attending Gynecologist, The Johns Hopkins Hospital; Consultant in Gynecology, The Union Memorial Hospital, Hospital for the Women of Maryland, Sinai Hospital and Church Home and Infirmary. Second Edition, with 479 Illustrations. Philadelphia: W. B. Saunders Co., 1947. Price $10.00.

Wharton has presented a clear, simply stated text on gynecology, giving a sufficiently complete description of the diseases presented also the arguments on both sides where there is controversy. The second edition has given opportunity to extend and bring down to date many passages.

Female urology naturally comes within the field of the gynecologist and is here presented in extended and specialized form. Water cystoscopy is new as is also a special chapter on the female urethra. Illustrations are sometimes more valuable than the text, and this book has these in profusion. The author is a recognized authority, and the book does him credit.

COPPER AND HEALTH. Issued by Copper & Brass Research Association, 420 Lexington Ave., New York 1947. Free upon request.

Many doubts concerning the role of copper in good health are dispelled in this complete and well-documented brochure.

Written in non-technical language, this booklet dis-

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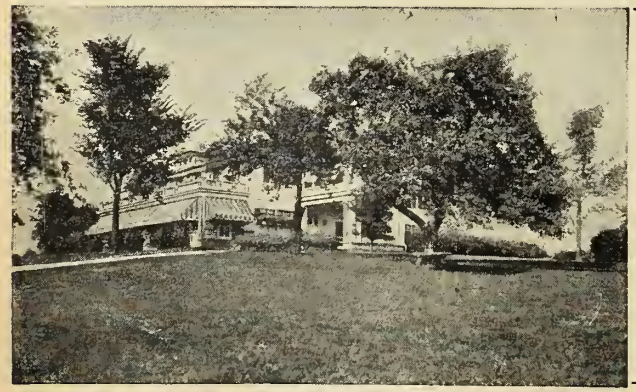

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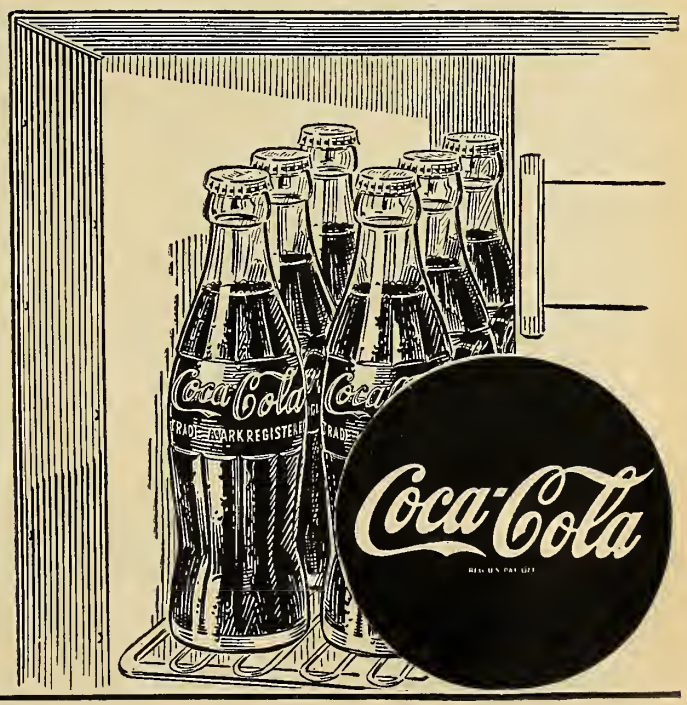

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proves a great many erroneous notions that copper is dangerous to human beings. Some of these misbeliefs and superstitions have been prevalent since ancient times.

Among the subjects covered are: toxicity of copper, copper as a nutrient, copper cooking utensils, copper in water supplies, copper in agriculture and—probably most important—copper in modern medicine.

It is concluded that copper, far from being dangerous to man's health, is one of the most useful metals known to man, physiologically as well as technologically. Copper is an essential element in the well-being and proper functioning of all life—vegetable, animal and human. A copy will be sent to anyone interested in this subject.

DIAGNOSIS AND TREATMENT OF DIARRHEAL DISEASES. By William Z. Fradkin, A.B., M.D., Assistant Attending Gastroenterologist, Jewish Hospital of Brooklyn; Physician-in-charge of Colitis Clinic, Department of Gastroenterology; Associate Bacteriologist, Colitis Division, Department of Laboratories, Jewish Hospital of Brooklyn. New York: Grune & Stratton, Inc. 1947. Price $6.00.

Diarrheal diseases are of increasing importance with the broader aspect of our doctors and returned soldiers. These diseases are prevalent, world wide, but with different causes in different parts. These causes now, however, are likely to be our next neighbor. This book describes the various diseases, their causes, also prevention and treatment. Diarrheas of infants, with their increased recent prevalence, get a large section. General practitioners will be especially helped by this timely book.

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OCCUPATIONAL DISEASES OF THE SKIN. By Louis Schwartz, M.D., Medical Director, United States Public Health Service, Chief Dermatoses Section; Associated Clinical Professor of Dermatology and Syphilology, New York University; Adjunct Professor of Dermatology and Syphilology, Georgetown University. Louis Tulapin, M.D., Clinical Professor of Dermatology and Syphilology, New York University, College of Medicine General Hospital; Associate Visiting Dermatologist and Syphilologist to Bellevue Hospital. And Samuel M. Peck, B.S., M.D., Dermatologist, Mt. Sinai Hospital, New York City; Medical Director, Inactive (R) U.S.P.H.S. Second Edition, Thoroughly Revised with 146 Illustrations and a Colored Plate. Philadelphia: Lea & Febiger, 1947. Price $12.50.

Dermatology is becoming more important in industry, with increasing exposure to irritants and conditions causing dermatoses. This book is complete and well illustrated. The trades and industrial conditions are described systematically, and many new chemicals and manufacturing methods are discussed. Prevention and treatment are especially featured. The general practitioner and the industrial doctor will find this book almost a necessity.

PARAVERTEBRAL BLOCK IN DIAGNOSIS, PROGNOSIS, AND THERAPY. MINOR SYMPATHETIC SURGERY. By Felix Mandl, M.D., F.I.C.S., Professor of Surgery, Hadassah University Hospital, Jerusalem. Translated by Gertrude Kallner, M.D. With a Foreword by Max Thorek, M.D., F.I.C.S., Professor of Surgery, Cook County Graduate School of Medicine, Chicago. New York: Grune & Stratton, 1947. Price $6.50.

Paravertebral block is the process of relieving uncontrollable pain. Diagnosis of conditions to be relieved and determination of just what blocking is required are essential. Mandl has spent twenty-five years in study and experiment and has produced a text most valuable, not alone to the surgeon, but to the Neuro-internist and the patient whose hopeless suffering may be relieved

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and life be made worth while. Methods and selection of cases are described and the end results discussed. Where possible, paravertebral block is advocated as a pilot to determine the efficacy of more radical operations.

A most interesting book.

DERMATOLOGIC CLUES TO INTERNAL DISEASE. By Howard T. Behrman, M.D., Assistant Clinical Professor of Dermatology, New York University College of Medicine; Adjunct Dermatologist, Mount Sinai Hospital and Beth Israel Hospital; Associate Dermatologist, Hillside Hospital; Diplomate of the American Board of Dermatology and Syphilology; Fellow of the American Academy of Dermatology and Syphilology. New York: Grune & Stratton 1947. Price $5.00.

This little book contains signs and symptoms of skin manifestations found in general diseases. Each article is rather short, but descriptive. This is diagnostic only, no treatment being discussed. The list of conditions is long and revealing, calling attention to many facts mostly forgotten, if ever known, but offering distinct help in diagnosis. There are 118 well selected illustrations.

New A.M.A. Directory.

Compilation of names will be started within the next few months, so that the 18th edition will be ready for delivery by at least the latter part of 1948. Since publication of the 1942 edition, information on 37,462 new physicians has been added to the files, and the names of 17,860 physicians who have died have been deleted.

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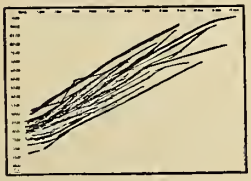

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The "Fifty Year Club" of the Michigan State Medical Society was created on the occasion of the 82nd Annual Session of the Michigan State Medical Society. Awards were presented to ninety-nine members of the Michigan State Medical Society who have practiced fifty years or longer in many communities of this state. The presentation was made amid fitting ceremonies by retiring President Wm. A. Hyland, M.D., on the occasion of Officers Night, September 24, in the Ballroom of the Pantlind Hotel, Grand Rapids.

Annually, as members of the Michigan State Medical Society attain fifty years of practice, they will be admitted as members of the MSMS "Fifty Year Club," with the special emblem of the club being presented to them at the annual session.

Charter members of the "Fifty Year Club," honored in 1947, were:

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STOP — LOOK — LISTEN

STOP telling the patient there is nothing wrong with him but his nerves—Don't say, "Go home and forget it."

LOOK for the facts as the patient sees them.

LISTEN attentively to the patient's story.

* * *

Whether or not you are in doubt about organic diseases, don't forget to search the personality of the patient.

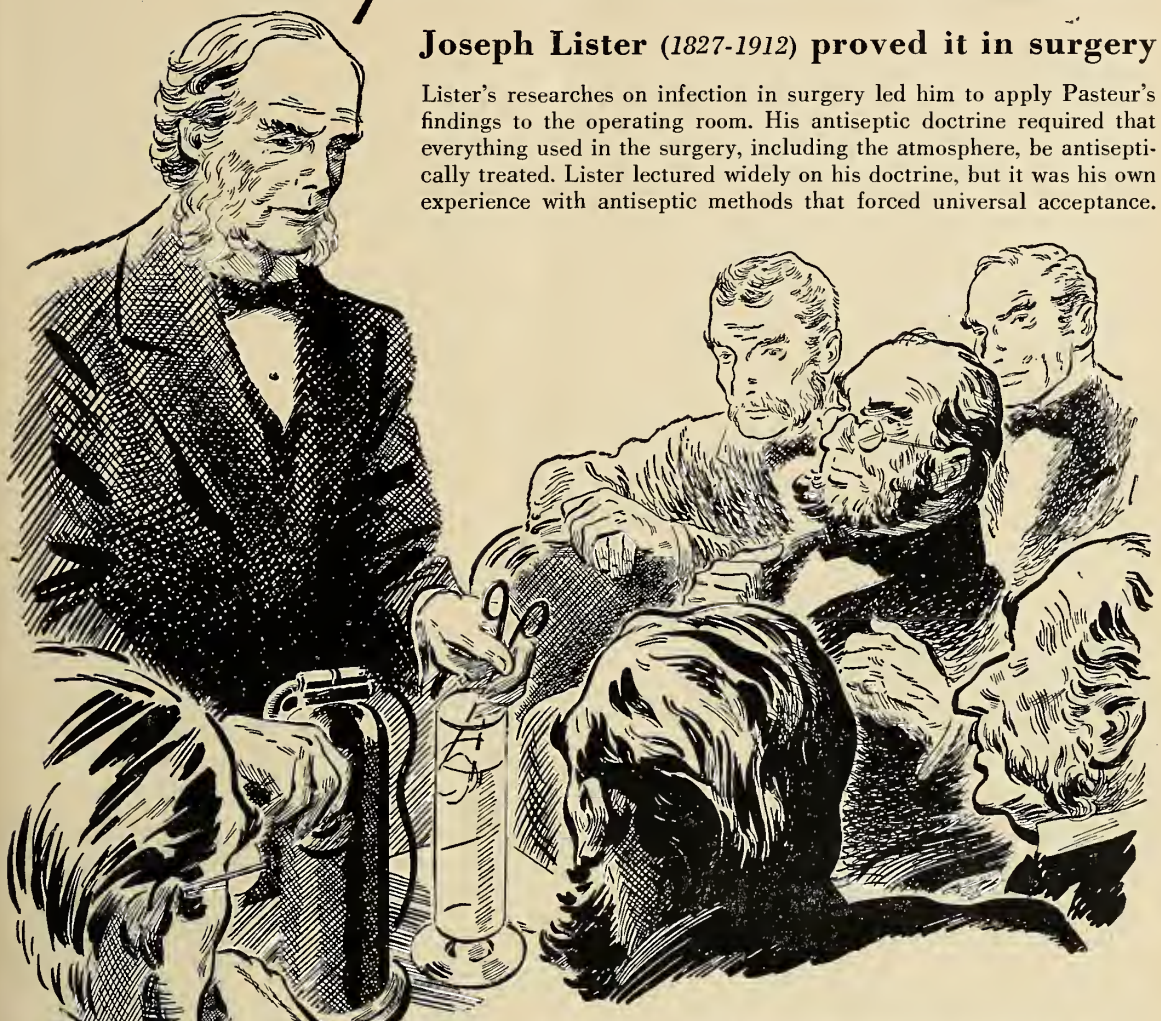
The neurasthenoid person is a moral masochist. Train him to think of his successes, not his failures.

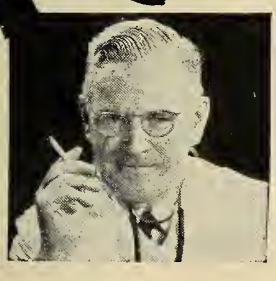
Intelligence and emotions do not parallel each other. You can have an I.Q. of 125 and still be an emotional moron.

Experience is the Best Teacher

Joseph Lister (*1827-1912*) proved it in surgery

Lister's researches on infection in surgery led him to apply Pasteur's findings to the operating room. His antiseptic doctrine required that everything used in the surgery, including the atmosphere, be antiseptically treated. Lister lectured widely on his doctrine, but it was his own experience with antiseptic methods that forced universal acceptance.





Yes, and experience is the best teacher in smoking too!

The wartime cigarette shortage was a real experience to smokers. That's when more and more people—smoking any brand that was available—learned the big differences in cigarette quality. So many smokers came to prefer Camels as a result of that experience that more people are smoking Camels than ever before. But, no matter how great the demand, we don't tamper with Camel quality. Only choice tobaccos, properly aged, and blended in the time-honored Camel way, are used in Camels.

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Winston-Salem, N. C.

You and Your Business

CONFERENCE ON CANCER PROBLEM

A one-day symposium conference on various phases of the cancer problem will be held in Grand Rapids on Thursday, November 13, 1947, under the auspices of the Kent County Medical Society. Patterned after highly successful programs held during the past year in Flint and Milwaukee, it will include three morning and four afternoon papers by men of national prominence regarding the diagnosis and treatment of several types of malignancies; the formal papers will be followed by panel discussions, which will include question-and-answer periods. Speakers already engaged include: Owen Wangensteen (Minnesota); E. A. Pohle (Wisconsin); Wm. Boyd (Toronto); Norman Miller (Michigan); and C. F. Geschickter (Georgetown). An evening session, open to the public, will be devoted to discussions of cancer as a public health problem and possibly some data regarding the use of radioactive substances in the treatment of cancer.

The conference is being sponsored by the KCMS as another step in its program of continuous education of the profession (and of the public) regarding the latest advances in the management of a disease which ranks second among the causes of death in the United States. All Michigan physicians will be welcome; individual notices will be sent to each of them well in advance of the date of the conference.

TRAINING FOR CITIZENSHIP

The American Bar Association is organizing a council of distinguished lawyers in public affairs. Support will be given to every movement for civic decency and betterment for the end of good government in all its phases.

Can the men of your profession shed your inferiority complex that you are not equipped for such civic work and pitch in? In the course of your daily work, you meet and can influence more people than we. You can find out what the people are thinking. You are natural-born leaders in your communities, as we are.

Can there be squeezed into your years of training—arduous long years, we know—a few hours of training in citizenship? I know there can be, because it must be.

Only in that way can we join in our common movement for the perpetuation of those principles of government on which the way of life of our people depends and on which your profession and mine depend.—C. B. Rix, President, American Bar Association, *Wisconsin Medical Journal,* August, 1947.

A PATIENT A DAY

The fight against socialized medicine must continue until the very last proponent of this enslavement measure is silenced. The pressure for the nationalization of the profession is lessened only to the extent of meeting the rapidly changing conditons in Washington.

In this nationwide fight, doctors have received valuable support from other professions. This support has been most effective, and, with the help of many able men in Congress, the forces of those who demand the continuance of the right to practice without control by government bureau or agency are holding the line.

Back home, there is something that we can do:

The membership of the West Virginia State Medical Association totals 1351. If every member in active practice will spend five minutes each day discussing with one patient the evils of socialized medicine, the total persons seen at the end of six months would add up to many thousands.

The possibilities of enlisting solid support at home are unlimited. Support at home definitely means needed support in Washington.

A patient a day! The effect of such a campaign in West Virginia would go a long way toward enlisting the solid support of our delegation in Congress. Participation by all the doctors in active practice in the United States would undoubtedly result in speeding the day when the threat that has been hanging over medicine for these many years would be but a memory.—Editorial, *West Virginia Medical Journal,* August, 1947.

with accent on the positive

Pasitive results form the keynote of clinical reports on "Premorin." Prompt remission of distressing menapausal symptams with comporotive freedam from untoword reoctions may usually be onticipated with "Premarin."

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Surgery in Doctor's Office Authorized by MMS

A major step forward has been made by Michigan Medical Service. In line with the policy of the Michigan State Medical Society to increase benefits wherever possible and to make prepaid medical-surgical service more easily obtainable to a larger number of people, Michigan Medical Service announced in September the following marked liberalization under its medical-surgical certificate:

SURGICAL SERVICES RENDERED TO A SUBSCRIBER IN THE OFFICE OF A DOCTOR OF MEDICINE OR IN THE OUT-PATIENT DEPARTMENT OF A REGULARLY ACCREDITED HOSPITAL, WHERE THE FEE, IN ACCORDANCE WITH MMS SCHEDULE OF BENEFITS, IS $20.00 OR MORE, WILL BE PAID.

This further liberalization, which went into effect September 1, 1947, was announced by R. L. Novy, M.D., President of Michigan Medical Service, in a letter to all physicians of Michigan, dated September 3, which stated:

"The Board of Directors recently authorized on an experimental basis, the payment of fees under our *Medical-Surgical Certificates,* for surgical services rendered to a subscriber in the *office of a doctor* of medicine or in the *out-patient department of a regularly accredited hospital,* where the fee, in accordance with Michigan Medical Service Schedule of Benefits for such surgical procedure is $20.00 or more. This liberalization goes into effect September 1, 1947.

"There are at the present time approximately 3,500 Medical-Surgical contracts issued. This form of contract has only been issued to small groups. It is our desire eventually to provide for office and out-patient surgery under the *"Surgical Contract."* However, it was decided that until we obtain some statistics, it will only be provided under the *"Medical-Surgical Contracts."*

"All subscribers holding 'Medical-Surgical Contracts' are being sent a copy of the enclosed 'Office Surgery Liberalization,' Form 2097.

"Only subscribers presenting Identification Cards with Service Codes 31, 32, 33, 34, 35, 36, 37, 38 or 39 are entitled to these liberalization benefits."

This increase in benefits applies *only* to the 3,500 medical-surgical certificates covering 8,000 members, and *not* to the certificate which provides only for surgical care. It is the desire of Michigan Medical Service eventually to provide for office and out-patient surgery under the "surgical contract;" however, until MMS obtains some statistics on its present liberalization, it will only provide office surgery, as above indicated, under the medical-surgical contract. The present liberalization is an experiment which Michigan Medical Service hopes will succeed, with the careful cooperation of Michigan doctors of medicine and their patients.

For additional information on this enlightened action of Michigan Medical Service, write J. C. Ketchum, Executive Vice President, MMS, 234 State Street, Detroit 26, Michigan.

EIGHTEENTH ANNUAL CLINIC HIGHLAND PARK PHYSICIANS' CLUB

Highland Park General Hospital, Highland Park, Michigan

November 12, 1947

Morning Session—8:30 A.M.

Clinical Pathological Conference
VIOLA BREKKE, M.D., Pathologist, Highland Park General Hospital, Highland Park, Michigan

"The Barren Marriage"
S. LEON ISRAEL, M.D., Associate Gynecologist, Graduate Hospital, University of Pennsylvania. Associate Gynecologist, Mount Sinai Hospital, Philadelphia, Pennsylvania.

"The Concept of Coronary Diseases and Its Management"
LOUIS N. KATZ, M.D., Director of Cardiovascular Research, Michael Reese Hospital, Chicago. Professorial Lecturer in Physiology, University of Chicago.

"The Practical Importance of the Rh Factor"
EDITH L. POTTER, M.D., Assistant Professor of Pathology, Department of Obstetrics and Gynecology, University of Chicago. Pathologist, Chicago Lying-In Hospital, Chicago.

Luncheon—12:45 P.M.
Courtesy Highland Park General Hospital

Afternoon Session—2:00 P.M.

"The Management of Venous Thrombosis and Embolism"
JOSEPHUS C. LUKE, M.D., Assistant Professor of Surgery, McGill University, Montreal, Quebec, Canada

"The Anesthesiologist and the Hospital Staff"
URBAN H. EVERSOLE, M.D., Director of Anesthesiology, Lahey Clinic, Boston, Massachusetts

"Preservation of the Anal Sphincter in Carcinoma of the Rectum"
HARRY E. BACON, M.D., Professor and Head of Department of Proctology, Temple University, Philadelphia, Pennsylvania

Cocktail Hour—7:00 P.M.
Detroit Leland Hotel

Dinner—8:00 P.M.
Detroit Leland Hotel

Toastmaster—VICTOR E. NELSON, M.D., President, Highland Park Physicians' Club

Address: "Humanics"
RALPH L. LEE, Ph.D., D.D., Public Relations Department, General Motors Corporation, Detroit, Michigan.

"Man that is born of a woman is of few days, and full of trouble." Job XIV, 1

Even in the face of great advances in medical knowledge, the lives of many infants are still literally "of few days and full of trouble," for 62.1% of the total infant mortality occurs within 30 days after birth.* During this fatal first month, every precaution must be taken to ward off troubles of early infancy.

Adequate nutrition, resistance to disease and freedom from hazardous diarrhea, colic or digestive upset all may be materially advanced by giving special attention to the first feedings.

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*Vital Statistics—Special Reports: Vol. 25, No. 12, National Office of Vital Statistics, Washington, D. C. (Oct. 15) 1946, p. 206.

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Annual Penberthy-Coller Medical Conference

At the annual Penberthy-Coller Conference held in Traverse City, July 31 and August 1, 1947, the following program was presented:

Thursday, July 31, 1947

A. C. Curtis, M.D.—"The Modern Treatment of Syphilis"

Reed M. Nesbit, M.D.—"The Use of Endocrines in the Treatment for Urogenital Tract Abnormalities"

H. A. Towsley, M.D.—"Vomiting of Infants"

Paul S. Barker, M.D.—"Differential Diagnosis of Jaundice"

Herman Riecker, M.D.—"Management of the Elderly Patient"

Fred J. Hodges, M.D.—"Some Interesting Experiences in Chest Diagnosis"

Carl Badgley, M.D.—"Brachialgia"

Edgar A. Kahn, M.D.—"Neurological Examination in General Practice"

A. C. Furstenberg, M.D.—"Tumors of the Salivary Glands"

Frederick A. Coller, M.D.—"Surgical Aspects of the Abdominal Wall"

Philip D. Wilson, M.D.—"Amputations"

Grover C. Penberthy, M.D.—"The Treatment of Trauma of the Abdomen"

Friday, August 1, 1947

Medical Clinic—Room 105—Munson Hospital

Surgical Clinic—School Room—Munson Hospital

Luncheon—Children's Clinic

Medical-Surgical Symposium—Room 105—Munson Hospital

One hundred and twenty-nine were in attendance. Registration was as follows:

Arthur C. Curtis, Ann Arbor; Reed M. Nesbit, Ann Arbor; W. B. Mitchell, Grand Rapids; William A. Jackson, Rogers City; Nicholas Lentini, Cheboygan; E. B. Miller, Manistee; Harry E. Merritt, Traverse City; Grover C. Penberthy, Detroit; Ruth E. Lalime, Bear Lake; Leo C. Brown, Solierring Corp.; B. M. Godfrey, Traverse City; G. H. Wood, Onaway; Gilbert B. Saltonstall, Charlevoix; William W. Norris, Portland; L. C. Beesley, Ann Arbor; Robert G. Mason, Birmingham; Edgar A. Kahn, Ann Arbor; W. Lloyd Kemp, Birmingham; Bernard M. Curtis, Traverse City; E. E. Hamilton, Traverse City; I. H. Sielke, Traverse City; Henry T. Johnson, Bellaire; A. F. Litzenburger, Boyne City; H. Kessler, Alpena; F. J. O'Donnell, Alpena.

Charles Paukstis, Ludington; J. C. Slaybough, Ludington; John D. Whitehouse, Traverse City; C. G. Clippert, Grayling; L. J. Goulet, Ludington; D. E. Wagoner, Lincoln; D. E. Salon, Traverse City; D. M. Baker, Traverse City; B. C. Fry, Ann Arbor; Harry Howard, Ann Arbor; R. S. McClintock, Charlevoix; William H. Pierce, Ann Arbor; J. R. Rodger, Bellaire; N. Huene, Traverse City; C. R. Keyport, Grayling; F. A. Faller, Ann Arbor; Philip D. Wilson, New York City; Paul Ivkovich, Reed City; Joe Zimmerman, Traverse City; J. J. Brownson, Kingsley; Homer A. Ramsdell, Manistee; J. Van Dellen, East Jordan; F. C. Mayne, Cheboygan; John W. Bunting, Alpena; R. J. Lentz, Traverse City; F. R. Way, Traverse City.

C. E. Lemen, Traverse City; R. C. Peckham, Gaylord; Harry Weitz, Traverse City; J. C. Lintner, Ludington; Robert J. Albi, Boyne City; K. M. Brownson, Traverse City; B. B. Bushong, Traverse City; W. J. Smith, Cadillac; F. H. Tower, Traverse City; Stanley A. Stealy, Grayling; Dr. Thirlby, Traverse City; Dr. Berghorst, Traverse City; J. W. Hall, Traverse City; F. H. Stone, Beulah; E. L. Becker, Cincinnati, Ohio; D. Goodrich, Traverse City; L. E. Grate, Charlevoix; P. S. Barker, Ann Arbor; F. J. Hodges, Ann Arbor; F. Towsley, Ann Arbor; S. C. Moore, Cadillac; R. E. Rice, Midland; H. H. Riecker, Ann Arbor; C. E. Merritt, Manton; S. N. Seltzer, Marion; Benton Holm, Cadillac.

F. E. Murphy, Cadillac; H. B. Kyselka, Traverse City; W. H. Norconk, Bear Lake; H. M. Jardine, West Branch; R. W. Light, Kalamazoo; W. H. Gallagher, Traverse City; C. E. Badgley, Ann Arbor; R. R. Huston, Elk Rapids; H. R. Moore, Newaygo; J. P. Klein, Fremont; P. B. Kilmer, Reed City; A. C. Tompsett, Hesperia; M. F. Osterlin, Traverse City; D. H. Duffie, Central Lake; E. F. Sladek, Traverse City; R. G. Lommen, Manton; R. P. Sheets, Traverse City; J. C. Kennedy, Cheboygan; W. M. Brownlee, Ann Arbor; J. M. Trudeau, Harbor Springs; C. G. Campbell, Ann Arbor; R. Lossman, Traverse City; F. G. Swartz, Traverse City; J. R. Weber, Traverse City; Greg P. Moore, Cadillac; A. C. Furstenburg, Ann Arbor.

E. C. Hansen, Manistee; B. H. VanLeuven, Traverse City; H. Osterhagen, Traverse City; J. F. Carrew, Marion; Fred R. Smith, Lake City; John H. Oliver, Chicago; R. L. Cannon, Traverse City; J. M. Cook, White Cloud; H. B. Haynes, Traverse City; D. G. Pike, Traverse City; Dr. Gauntlett, Traverse City; Carl Badgley, Grand Rapids; D. C. Burns, Petoskey; Andrew Sharf, Petoskey; Howard C. Jackson, Kalamazoo; John G. Beall, Traverse City; E. J. Bolan, Suttons Bay; F. F. McMillan, Charlevoix; G. A. Drescher, Lewiston; G. L. McKillop, Gaylord; H. F. Mattson, Hillsdale; J. T. Jerome, Traverse City; Milton A. Darling, Detroit; L. Showalter, Cadillac; R. Daugherty, Cadillac; J. T. Sample, Saginaw.

KEEPING UP WITH MEDICINE

PRURITUS ANI with its edema of the skin, thickening papillitis, may well be allergic and this should always be considered before surgical interference, x-ray treatment, local injections, divisions of nerves, and other radical procedures are undertaken.

* * *

DISEASE results when the favorable influences to which we are constantly exposed are inadequate or incomplete or when the unfavorable influences are excessive, or when the genetic endowment is made inadequate to meet even an average balance of the favorable and unfavorable influences.

* * *

LACK of enough meat, whole wheat, and other vitamin-B containing foods will make our young people develop serious psychoneurotic illness. Depression, hysteria, obsessive worry, and too much emotion are bound to be the results of partially feeding a starving people. This leads to war.

Ohio Medical Journal, August, 1947.

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High-concentration Elixir Pyribenzamine hydrochloride now provides a second administration form of this proved antihistaminic. Containing 20 mg. of Pyribenzamine hydrochloride per 4 cc. (teaspoonful), the Elixir has obvious advantages in special cases, notably in infants and children, and in adults who prefer liquid medication.

Scored tablets of Pyribenzamine also facilitate small dosage when indicated—the 50 mg. tablets are easily broken to provide 25 mg. doses.

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Political Medicine

CHAIRMAN OF MEDICAL BOARD UNITED MINE WORKERS WELFARE AND RETIREMENT FUND

Dr. R. R. Sayers, medical director, U. S. Public Health Service, and Director of U. S. Bureau of Mines since 1940, has been granted leave without pay to accept the chairmanship of the medical board established by the Trustees of the Welfare and Retirement Fund of the United Mine Workers of America. His appointment was announced by Dr. Thomas Parran, Surgeon General, U. S. Public Health Service.

Assignment of Dr. Sayers to this position is in line with Public Health Service policy of making expert personnel available to official and voluntary, non-profit organizations to assist in the developmental stages of new and significant health undertakings.

In his new position, Dr. Sayers will advise trustees of the miners' fund on health and medical problems. He will also assist State and local public health authorities, as well as coal operators and unions, in carrying out recommendations contained in the Medical Survey of the Bituminous Coal Industry issued last spring by Rear Admiral Joel T. Boone. This survey, provided for by the Lewis-Krug agreement when the government was operating the mines, is the first nationwide report on living and working conditions of miners. Its recommendations include:

Establishment of strong local health departments; improvement of basic sanitation; organization of health education programs, including health demonstration projects by medical societies or philanthropic foundations; industry wide studies and research on nature, occurrence, and control of occupational diseases and disabilities; rehabilitation programs; expansion of company industrial medicine programs, including physical examinations of employes, and provision of adequate first aid and other medical facilities; improvement of size and quality of hospitals and out-patient clinics; modification and consolidation of prepayment plans for medical care; and improvement of housing and of recreational facilities.

These and other recommendations of the survey call for close co-operation among miners, operators, medical societies, health organizations and Federal, State and local official agencies. To implement their work, the survey recommended that "an outstanding leader of the civilian profession be on any trusteeship established for medical care and hospitalization." Dr. Sayers' appointment is in line with this latter recommendation.

JAP HEALTH SURVEY PLAN ASSAILED

A House subcommittee charged today that the Social Security Board and the Public Health Service are misusing Federal funds "to advance the world program for socialized medicine" and urged that a health mission to Japan be delayed.

Investigators of the subcommittee on publicity and propaganda of the House Committee on Expenditures in the executive departments are now conducting a preliminary inquiry into the proposed special mission scheduled to leave Thursday.

Representative Harness (R., Ind.), chairman, expressed "hope that some official action in the executive branch may delay departure" until the investigation is completed and "all the facts (are) presented to the Department of Justice."

Prosecution Demanded

Mr. Harness, during the recent session of Congress, declared that out of a total $75,000,000 used annually for propanganda purposes in the executive branches, at least six agencies are illegally expending sums in support of compulsory health insurance.

He voiced a demand that Tom C. Clark, Attorney General, "prosecute these violations to prevent further disregard by Federal employes and agencies of the law.

In his statement, Representative Harness asserted that "regardless of what action may be taken in the executive branch, it will be the firm purpose of this committee to complete its investigation of this matter, and lay the complete picture before the committees on appropriations in the next Congress and such other committees as have these matters within their jurisdiction."

"Evidence Is Clear"

Mr. Harness stated that the committee was convinced the mission, sponsored jointly by the Social Security Board and the Public Health Service, is committed in advance to a national program for socialized medicine in Japan.

"The evidence likewise is clear," the chairman declared, "that the Wagner-Murray-Dingell bill already has been selected as the beginning point of the mission's health survey in Japan.

"We feel that the nominal Japanese 'request' for such a mission was more a matter of departmental routine in Washington than a bona fide expression of Japan's needs and wishes in the matter of United States assistance in national health rehabilitation."

"All Militant Advocates"

The men who are to consult with Japanese authorities, it was contended, are mainly Federal employes now engaged in various phases of public health and social

(Continued on Page 1134)

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JAP HEALTH SURVEY PLAN

(Continued from Page 1132)

security administration, "all of whom are known to be militant advocates of the Wagner-Murray-Dingell bill."

Representative Harness said that this plan for "socialized medicine" has been urged four times in Congress and each time has been turned down in committee.

"Our information," he continued, "is that the proposed mission already has sent to Tokyo copies of the several versions of the bill, as introduced in Congress since 1939, together with voluminous hearings before the Senate Labor Committee presenting the views of the United States advocates of socialized medicine."

The project was attributed to the two sponsoring agencies. It was added that former social security workers were attached to the Public Health and Welfare Section of the occupation authority in Tokyo in preparation for the mission.

The Harness statement further alleged that:

"Our committee has received and carefully studied the complete file of radio communications between Tokyo and Washington which laid the groundwork for the appointment of the health mission. No high-ranking occupation authorities figured in these arrangements.

"Did Not Originate in Japan"

"Our conclusion is that the demand for this mission did not originate in Japan, but among certain officials of the Social Security Board in Washington."

According to the subcommittee chairman, the investigators found that "one man selected by the board to be a member of the Tokyo mission has returned only recently from a special assignment with the British Ministry of Health, in London, where he assisted in advancing a comprehensive program of socialized medicine through the British Parliament."

Specifically, he said the "scheme for a Japanese health mission" originated in social security's bureau of research and statistics, which he added would be a subject of continued investigation.

Asks Public Attention

The Indiana legislator pointed out he felt that public attenion should be focused on the Japanese project before it leaves the capital.

"However concealed in official accounting procedures and inter-departmental transfers of funds and authorizations," he concluded, "such a use of Federal appropriations appears to this committee to present a clear misapplication of Federal monies, far beyond any program or purpose ever within the intent of Congress."—ROBERT W. RUTH, *The Sun,* Baltimore, August 27, 1947.

American Medical Association

The American Medical Association is presently using 310 tons of paper a month for the journal, *Hygeia* and the many other special journals devoted to specific fields of medicine.

Say you saw it in the Journal of the Michigan State Medical Society

The JOURNAL

of the Michigan State Medical Society

Issued Monthly Under the Direction of the Council

VOLUME 46 OCTOBER, 1947 NUMBER 10

"Dumping Syndrome" Following Anterior Gastro-jejunostomy

A Follow-up Study of Seventy-five Partial Gastric Resections

By Charles S. Kennedy, M.D., F.A.C.S., Roland P. Reynolds, M.D., F.A.C.S., and Meyer O. Cantor, M.D., F.A.C.S.
Detroit, Michigan

MUCH has been written and many theories advanced to explain that symptom-complex collectively included under the name of "dumping syndrome" or "dumping stomach." From this, we are led to infer that this symptom-complex characterized by weakness, rapid pulse, perspiration, vertigo, or fainting which occurs in approximately 10 per cent of cases reported[2] as having had partial gastric resection, is due to too rapid emptying or dumping of the gastric contents into the jejunum. In recent years, other theories have been advanced to explain this symptom-complex. The hyperglycemic theory[3] which bases the symptomatology on the idea of a sudden hyperglycemia. The dietary theory[1] which notes that such patients are especially intolerant of high-fat intake and are benefited by a high-protein intake. The nutritional theory[8] which considers the nutrition of such patients as a causative factor. The stomal theory[4] which postulates that the size of the stoma (anastomosis) in the Polya operation is too large and hence causes dumping. This group proposes the Hoffmeister operation to reduce the incidence of the symptom-complex.

In studying this problem clinically, we endeavored to standardize our operative procedure as far as was reasonably possible in an effort to eliminate some of the above-mentioned theories as to causation.

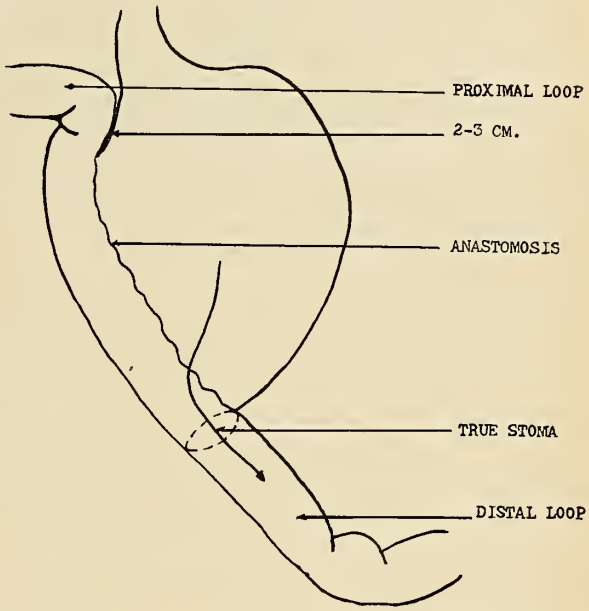

Fig. 1. The "true gastric stoma" is merely the lower end of the anastomosis (the lumen of the distal loop of jejunum) and is not the entire anastomotic circumference.

In a previous paper,[5] we have been able to demonstrate a fact with which many surgeons are conversant but overlook, namely, that the "true gastric stoma" is not the entire circumference of the anastomosis but is merely the lower end or in other words the lumenal diameter of the distal loop of jejunum (Fig. 1). This being the case, the upper jejunum (distal loop) cannot accept gastric

From Grace Hospital, Detroit, Michigan.

contents at a faster rate than the jejunal lumenal diameter will permit. Since this lumenal diameter is almost constant in all patients of the same size, there should be no great variation in the rate of emptying if the remaining stomach is in tone and if the same food is eaten. Johnston and Ravdin[9,10] have well demonstrated that certain types of food can influence the rate of gastric emptying. If we consider that the stomach is a funnel, which in truth it is, then the true gastric stoma remains its outlet. Since this diameter is a relatively fixed one, overfilling of such stomachs would result in a feeling of precordial distress or regurgitation much like overfilling of any other funnel *in vitro*. Pouring more liquid into a funnel *in vitro* does not result in a dumping through the outlet—the rate of flow remains uninfluenced. Granted that the jejunum has a power of distention not found in a funnel *in vitro,* yet the stoma itself becomes relatively unyielding as a result of a hypertrophy of the circular muscle fibers of the jejunum[7] causing a pseudo-sphincter formation[6] (Fig. 3). Because of this, overdistention of the distal loop of jejunum is not very likely. For these reasons, we feel that the symptom-complex is misnamed when it is called "dumping syndrome."

In standardizing our operative procedure, we remove the same amount of stomach as far as is reasonably possible considering the anatomical differences in stomach size. We use as the upper limits of our resections, a point on the lesser curvature at which the left gastric artery comes in and a point on the greater curvature at the so-called "bare area" of the stomach (Fig. 2). The lower limits of the resection would fall in the duodenum below the ulcer-bearing area. In all cases, an anterior gastro-jejunostomy of the Polya type was performed, except three cases in which a Hoffmeister anastomosis was done for reasons of safety due to the height of the resection.

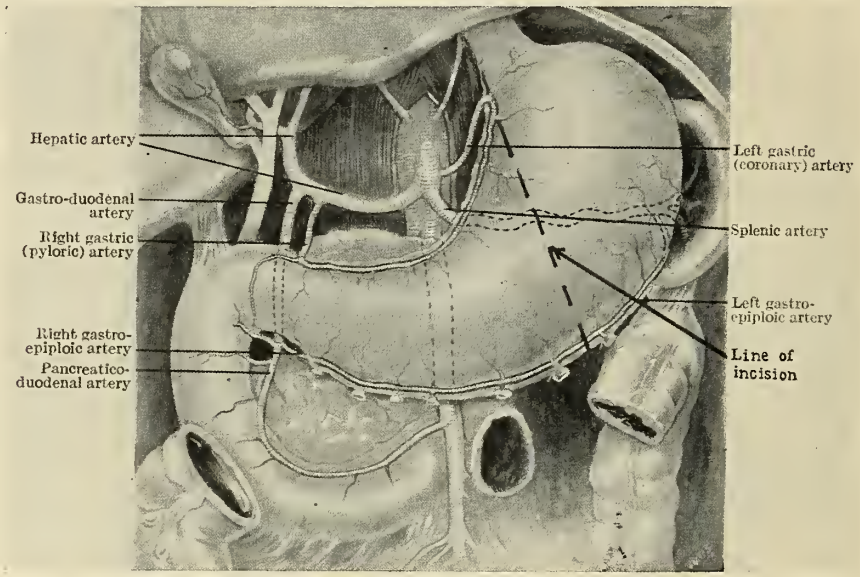

Fig. 2. The resection is ample enough to remove practically all the acid-forming tissue of the stomach. Such standardization results in the postoperative stomach being of an almost uniform size regardless of the variation in preoperative stomach size, (From Maingot, R.: Technique of Gastric Operations).

Finsterer's method of suturing the proximal limb of the jejunum along the lesser curvature for a distance of 2 centimeters, in an effort to prevent reflux of gastric contents into this proximal loop, was utilized in all cases.

The patients were followed for a five-year postoperative period in an effort to ascertain whether any of the symptoms included in the symptom-complex known as the "dumping syndrome" had occurred. Since at least two-thirds of all such dumping stomachs appear within two years of the operation, such a survey would hold a relatively high degree of accuracy. Follow-up letters were sent to 100 consecutive patients. Of this hundred, seventy-five replies were received. These seventy-five cases are the basis for this report.

In our discharge instructions, all patients were told to eat freely of any food that they desired.

No attempt was made to restrict their dietary either quantitatively or qualitatively within reasonable limits.

Anterior Gastro-jejunostomies

Name	*Age*	*Sex*	*Diagnosis*	*Dumping syndrome*
L.B.	48	M	Duodenal ulcer	no
J.C.Z.	45	M	Marginal ulcer	no
L.V.C.	35	M	Duodenal ulcer	no
D.E.H.	55	M	Duodenal ulcer	no
A.M.W.	42	M	Gastric ulcer	no
B.W.	45	M	Gastric ulcer	no
C.H.	34	M	Duodenal ulcer	no
H.L.D.	56	M	Duodenal ulcer	no
A.W.	46	F	Duodenal ulcer	no
S.C.	38	M	Duodenal ulcer	no
W.B.	51	M	Duodenal ulcer	no
L.G.	50	M	Duodenal ulcer	no
A.N.	62	M	Duodenal ulcer	no
D.R.	28	M	Duodenal ulcer	no
G.P.	48	M	Duodenal ulcer	no
W.S.H.	65	M	Duodenal ulcer	no
E.F.	34	F	Duodenal ulcer	no
D.W.	39	F	Gastric ulcer	no
H.A.M.	52	M	Gastric ulcer	no
W.G.	44	M	Duodenal ulcer	no
H.MacD.	48	F	Duodenal ulcer	no
J.D.	62	M	Marginal ulcer	no
T.H.H.	64	M	Duodenal ulcer	no
H.M.B.	39	M	Duodenal ulcer	no
W.R.M.	48	M	Gastric ulcer	no
R.M.	38	M	Duodenal ulcer	no
C.C.B.	47	M	Duodenal ulcer	no
D.W.O.	68	M	Duodenal ulcer	no
S.M.	52	F	Duodenal ulcer	no
G.H.	53	M	Duodenal ulcer	no
S.G.	38	M	Duodenal ulcer	no
L.P.	55	M	Carcinoma of stomach	no
T.S.	35	F	Gastric ulcer	no
J.L.	48	M	Duodenal ulcer	no
H.D.F.	58	M	Duodenal ulcer	no
J.P.H.	55	M	Duodenal ulcer	no
K.H.	45	M	Duodenal ulcer	no
J.H.B.	42	M	Duodenal ulcer	no
H.F.A.	74	M	Duodenal ulcer	no
J.W.K.	37	M	Duodenal ulcer	no
J.C.	32	M	Duodenal ulcer	no
G.P.	75	M	Duodenal ulcer	no
G.N.	27	M	Duodenal ulcer	no
W.E.H.	63	M	Duodenal ulcer	no
W.H.	45	M	Duodenal ulcer	no
L.R.D.	45	F	Duodenal ulcer	no
F.R.G.	36	F	Duodenal ulcer	yes
R.T.	50	M	Duodenal ulcer	no
A.P.	55	M	Duodenal ulcer	no
S.E.E.	50	M	Duodenal ulcer	no
A.M.	48	M	Duodenal ulcer	no
D.J.G.	60	M	Duodenal ulcer	no
H.S.	45	M	Duodenal ulcer	no
H.F.W.	50	M	Duodenal ulcer	no
W.H.W.	48	M	Duodenal ulcer	no
S.J.M.	38	M	Duodenal ulcer	no
M.C.	65	M	Duodenal ulcer	no
H.J.G.	60	M	Duodenal ulcer	no
McC D.D.	50	M	Duodenal ulcer	no
W.M.	48	M	Duodenal ulcer	no
A.W.	48	M	Gastric ulcer	no
H.M.	55	M	Gastric ulcer	no
W.H.	64	M	Duodenal ulcer	no
F.K.	50	F	Duodenal ulcer	no
F.K.	54	M	Duodenal ulcer	no
E.W.E.	56	M	Duodenal ulcer	no
T.W.N.	68	M	Duodenal ulcer	no
H.A.	41	M	Duodenal ulcer	no
J.G.	66	F	Duodenal ulcer	no
J.S.M.	47	M	Duodenal ulcer	no
R.H.	58	M	Gastric ulcer	no
J.C.	34	M	Gastric ulcer	no
E.D.S.	51	M	Duodenal ulcer	no
J.B.E.	48	M	Duodenal ulcer	no

In reviewing the above list of patients operated upon, we find only one patient (F.R.G.) who manifested the symptom-complex known as the "dumping syndrome." This woman is a very nervous, high-strung individual with a multiplicity of complaints other than those referable to her gastrointestinal tract. Because of this, we feel that her gastrointestinal complaints should be taken with some reservations. However, we include her as a case of dumping to avoid any possible chance of self-delusion.

The fact that only one patient out of seventy-five presented this symptom-complex gives us an

Fig. 3. The patient had been resected five years previously. Note the outpouching of jejunal wall of anastomosis and displacement of true gastric stoma to the left. Note also pseudo-sphincter at the true gastric stoma. At operation, this was seen to contract and relax and behave much the same as the true sphincter would.

incidence of 1.3 per cent. Since all these patients with but three exceptions, had a Polya type of resection, it should be quite obvious that the diameter of the anastomotic lumen (called the stoma by some surgeons) does not have any bearing upon this symptom-complex. All of these patients have had an ante-colic gastro-jejunostomy so that a loop of jejunum approximately 50 centimeters from the ligament of Treitz is used in the anastomosis. Using a loop of jejunum far from the ligament of Treitz does not seem to influence this symptom-complex as the proponents of posterior gastro-jejunostomy would have us believe.

The fact that in all cases we used the Finsterer method, tacking the proximal limb of jejunum along the lesser curvature of the stomach to prevent reflux of gastric contents, may contribute to the excellent results obtained in so far as the "dumping syndrome" is concerned.

It is highly probable that our very low incidence of the dumping symptom-complex may be due to

a combination of factors. Among these are the Finsterer method of tacking the proximal loop of jejunum, the fact that a high-resection is always done removing all antral mucosa in all cases, and the fact that following the resection the line of the anastomosis is vertical so that the "true gastric stoma" assumes anatomically the position of the funnel tip. In many posterior gastro-jejunostomies the line of the anastomosis is apt to be transverse so that the "true gastric stoma" would not fall at the apex of the funnel but would lie rather to the left. This would permit a downward pressure of the gastric contents upon the jejunal wall of the anastomosis. It may be possible that such downward pressure might initiate some nerve impulses through the autonomic system that would result in the symptom-complex in question.

Another point that may be responsible for our low incidence of this symptom-complex is the fact that we do not restrict the diet of our patients either qualitatively or quantitatively. The result of this is that these patients as a general rule are contented and resume normal activity rapidly. Their nutrition generally is much better than those whom we formerly restricted. The improvement in nutrition of these patients postoperatively may be an important factor in our results.

Conclusions

1. A series of seventy-five partial gastrectomies with ante-colic gastro-jejunostomies are reported.
2. Only one patient reported the presence of "dumping syndrome" an incidence of 1.3 per cent.
3. We do not feel that the circumference of the anastomosis (stoma for many surgeons) has any bearing upon the question.
4. Since all the cases in our series had an ante-colic gastro-jejunostomy with the line of the anastomosis vertical, whereas in the posterior gastro-jejunostomy the line of the anastomosis is apt to be transverse, it is possible that this may be a factor in the development of this symptom-complex.
5. The excellent nutrition of this group of patients and the speedy return to a normal dietary status may be contributary to the low incidence.

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References

1. Allen, A. W., and Welch, C. E.: Subtotal gastrectomy for duodenal ulcer. Ann. Surg., 124:688-703, (Oct.) 1946.
2. Berkman, J. M., and Heck, F. J.: Symptoms following partial gastric resection. Gastroenterology, 5:85-95, (Aug.) 1945.
3. Glaessner, C. L.: Hyperglycemic shock. Rev. Gastroenterol., 7:528-533, 1940.

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Fish Tapeworm Infestation Due to Sampling of "Gefülte" Fish or Its Soup Before Adequate Cooking

Report of Eleven Cases with a Discussion on the Epidemiology of the Disease

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THE PURPOSE of this paper is to call attention to the infestation of broad fish tapeworm, Diphyllobothrium latum, in Jewish women, by the tasting of soup (in which infested fish is cooked) during the preparation of a favorite Jewish dish, commonly called "gefülte fish" (an appetizer), and not necessarily by the "eating of raw fish," or swallowing of the sampled food. "Tasting" of the soup is resorted to, usually before the dish is adequately cooked, to determine the need for additional seasoning.

Eleven cases, all Jewish women, are reported in this communication. In addition, the literature is reviewed to date with special attention to the epidemiology of fish tapeworm infestation.

History

Walker[48] and Leidy[15] in 1879 announced the first case of infestation with Diphyllobothrium latum in an American who emigrated from Sweden. In 1897 Warthin[51] predicted that fish tapeworm would become endemic in Michigan.

In 1901 Hamilton[9] recorded the first native-

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Canadian infestation (Quebec), and Nickerson[28] in 1906 reported the first native-United States case (Minnesota). In 1907 Stiles,[35] warned that human infestation with the fish tapeworm "will become more commonly known in the United States."

Birkeland,[2] in a very comprehensive report on the Bothriocephalus Anemia, reviewed the literature up to 1930. He listed 259 cases from North America. Twenty-two of these were natives of the United States and two were natives of Canada. The remaining cases comprised 214 who immigrated into this country, and twenty-one who immigrated into Canada. Most of the immigrants came from Finland. Several came from Sweden, Russia and Poland. Three were born in Germany, two in Austria, two in Lithuania, and one each in Scandinavia, Rumania and Japan.

Since Birkeland's report, sixty-two additional cases were recorded for the United States, (twenty-eight native born and thirty-four foreign born), and seventy-two additional cases for Canada, (twenty-one native born and fifty-one foreign born). These are listed in Table I. Thus, since 1879, when the first North American case was announced, a total of 393 cases of fish tapeworm infestation are recorded in the literature for North America. Of these 298 were reported for this country (248 foreign born and fifty native born), and ninety-five for Canada (seventy-two foreign born and twenty-three native born). These are exclusive of the eleven foreign born cases we are reporting in this communication and which are included in Table I.

TABLE I. NUMBER OF CASES WITH FISH TAPEWORM INFESTATION RECORDED IN THE LITERATURE FOR THE UNITED STATES AND CANADA TO DATE

Investigator	Bibliography	Year	United States		Canada		Total
			Native	Foreign Born	Native	Foreign Born	
Birkeland, I. W.	2	1930	22	214	2	21	259*
Lyon, M. W.	17	1926	1	..	..	..	1
Levy, D. J. and Pierson, M.	16	1926	1	..	..	..	1
McGarvan, E. G. and Songkla, M.	24	1928	2	..	..	..	2
Ingall, M. and Freeman, H.	13	1930	1	6	..	..	7
Lyon, M. W.	18	1930	..	1	..	..	1
Myers, T.	26	1930	2	..	..	..	2
Pilot, I. and Levin, J. M.	31	1931	5	..	..	..	5
Plotz, M.	32	1932	5	16	..	..	21
Waters, H. S. and O'Connor, F. W.	52	1932	3	..	..	..	3
Canavan, W. P. N.	4	1932	..	1	..	..	1
Magath, T. B. (Mayo Clinic)	21	1933	3	7	..	3	13**
Cushing, H. B. and Bacal, H. L.	5	1934	..	..	21***	41	62
McClure, W. B. and Teskey, L.	23	1934	..	..	..	7****	7
Ronka, E. K. F.	33	1934	..	1	..	..	1
Hunnicutt, T. N.	12	1935	..	1	..	..	1
Sunkes, E. J. and Sellers, T. F.	37	1937	..	1	..	..	1
Headlee, W. H. and Kmecza, J. J.	11	1939	1	..	..	..	1
Summers, W. A. and Weinstein, P. P.	36	1943	3	..	..	..	3
Muntz, H. M.	25	1945	1	..	..	..	1
Total			50	248	23	72	393
Sandweiss, D. J. and Sugarman, M. H.		1946	..	11	..	..	11
Grand Total			50	259	23	72	404

* Cases accumulated from the literature by Birkeland.[2]

** Magath reported twenty-five cases from the Mayo Clinic. However, twelve of these also appeared in Birkeland's report[2] and were thus excluded as duplications.

*** Nine native Canadian cases were reported, and mention is made of twelve other cases to be reported later.

**** One foreign born Canadian case was reported and references is made to six other cases not yet reported.

The exact incidence of fish tapeworm in this country is not known since tapeworm infestation is not a reportable disease.

Epidemiology

Fish tapeworm imported to North America.—Diphyllobothrium latum infestation in the human has become endemic in this country, as a result of immigration of infested persons from the Baltic countries and Lithuania, where human infestation runs from 15 to even 95 per cent of samples of the population studied. According to Magath,[21] "It is definitely known that many of these people brought, besides their baggage, anywhere from one to five healthy tapeworms."

TABLE II. LIST OF NORTH AMERICAN LAKES KNOWN TO HARBOR INFESTED FISH (FROM MAGATH—1933)

Author	Year	Lake	Region, State or Province	Degree of Infestation
		Burntside	Ely, Minn.	Medium
Magath	1931	Long	Ely, Minn.	Heavy
		Winnipeg	Manitoba	Heavy
Magath and Essex	1931	Vermillion	Tower, Minn.	Light
		Devil's Track	Minnesota	Medium
		Fall	Winton, Minn.	Heavy
		Portage	Michigan	Medium
		Superior (shore)	Michigan	Light
		Lake of the Woods	Minnesota	Very Light
Vergeer	1928	Basswood	Minnesota	Very Light
		Nipigon	Ontario	Heavy (?)
		Manitoba	Manitoba	Light
		Lac La Biche	Alberta	Very Light
		Lesser Slave Lake	Alberta	Very Light
Ward	1926	East Okoboji	Iowa	Very Light

Life cycle.—It is conservatively estimated by Lyons[17] that an infested individual will excrete with his stools more than 1,000,000 eggs a day. The ova are not well developed at the time they are deposited with the feces, but if they get into the water, the typical six-hooked embryos develop in ten days to two weeks. The embryos are ciliated, so that they can swim around in the water after they are released. They die in a few hours unless eaten by certain small crustaceans, the majority of which belong to the genus Diaptomus.[21,45] The latter are the first intermediary hosts in the life cycle of the parasite, and within their body-cavity, the embryo develops into the procercoid stage in about three weeks.

If the Diaptome are eaten by a fresh water fish, which serves as second intermediary host, the procercoids are freed and migrate into the body cavity, muscle, or other tissues of the fish and grow until they develop into the stage known as plerocercoids. The fish are then consumed by fish eating human beings, dogs, cats, bears and foxes, and perhaps by other carnivora, resulting in infestation with the worm.

Magath,[19] Essex,[6] Vergeer,[43] and Nicholson[29] have shown that the life history of the parasite is completed both in the United States and in Canada. Both intermediary hosts are present in the endemic lakes.

Distribution.—Diphyllobothrium latum is common in persons living in the Baltic countries, Western Russia, Finland, parts of Scandinavia and in certain endemic foci of the United States and Canada. The parasite also occurs in the lake regions of Italy, Switzerland, parts of Germany, in the valley of the Danube, particularly in Rumania. According to the Manual of Tropical Medicine,[27] it has been reported in Manchuria, Japan, portions of Siberia and scattered areas of Africa (but Magath[20] advises us that, "There is some circumstantial and biological evidence to doubt the validity of these cases"). Cases have also occurred in Greenland.

Endemic Areas in the United States and Canada.—In this country and in Canada the parasite occurs mainly in Northern Wisconsin, Minnesota, Michigan and in provinces of Canada bordering on those states. Cases have also been reported from Indiana, Massachusetts, Oklahoma, Ohio, Washington, D.C., Louisiana, Missouri, New Mexico, Illinois, Iowa, New York, Pennsylvania, Colorado, Texas, and Florida.

Ward,[50] Vergeer,[44] Magath,[21] and Magath and Essex[22] list the lakes of North America, from which infested fish have been procured. Table II shows that the endemic lakes in North America are situated in the north central portion of the United States and in the south central portions of Canada.

The degree of infestation in the various lakes depends largely on the racial origin of the population living at or near the water front, infestation being greatest near communities of Finlanders and Russian and Polish Jews. According to Magath[21] infestation of lakes is maintained by sewage, containing infested human excreta.

Dogs may also be responsible for infesting lakes with Diphyllobothrium latum. According to Vergeer,[47] Indians and others are accustomed to feed their dogs raw wall-eyed and great northern pike. The dogs thus become an important reservoir of broad tapeworm and infest the fish in the lakes. Actually, dogs have been found to harbor from five to nineteen broad tapeworms. "No doubt, they could carry even heavier infections, but as the numbers increase, the size tends to decrease."[45] Bears, as well as dogs, may perpetuate the fish tapeworm cycle.[42] The evidence that cats play a role is less definite but it has been indicated that cats serve as definitive hosts. These infested animals do not play a direct role in human infestations, but only an indirect one by infesting lakes and fish.

Type of fish infested with fish tapeworm.—According to Vergeer[43] and Magath,[21] the following

fish in the United States have been shown to harbor live pleroceroids: Esox lucius (pickerel or great northern pike), Stizostedion vitreum (wall-eyed pike), S. canadense griseum (sand pike), Lota maculosa (burbot) and Perca flavescens (yellow perch). It was implied that trout also transmit the disease but Vergeer[42] failed to verify this. We were also advised that neither salmon nor any salt water fish has ever been incriminated in the transmission of fish tapeworm infestations, although Vergeer[46] states, "The only other species of fish that I have reason to suspect of being a host is Pacific (Alaskan) salmon and landlocked eastern salmon."

Cause of extra-endemic infestations.—Vergeer[41] points out that a large percentage of cases of Diphyllobothrium latum in the United States outside the known endemic areas, may be attributed to the eating of infested fish imported from Canada. The United States Tariff Commission, according to Vergeer,[41] found that during 1919-1924 an average of 7,156,395 pounds of yellow pike or wall-eyed fish were imported annually from Canada. This was 73.4 per cent of total consumption of this species in the United States. The most important sources of these fish are Lake Winnipeg (the largest of commercial importance), Lake Manitoba, Lake of the Woods and Lake Winnepegosis. Most of the fish shipped were fresh (without being frozen), since Jewish trade in the United States is willing to pay a premium for fresh wall-eyed fish. Faust[8] likewise has pointed out that fish shipped from endemic foci to large cities such as New York, St. Louis, Missouri, et cetera, have been found to be the sources of human infestations in such extra-endemic areas.

Vergeer[43] states that Portage Lake region in Northern Peninsula of Michigan, with considerable Finnish population, is an endemic area. Movement of fish infested with Diphyllobothrium latum from Portage Lake out into Lake Superior brings these fish into range of commercial fishing operations and thus may be a factor in the dissemination of the infestation in the territory to which the fish from this region is shipped.

Magath[21] cites fish hatcheries as a possible cause for extra-endemic infestation: "Certain fish hatcheries are situated on infested lakes and, since plankton are readily eaten by the hatchery fish, some fish may become infested and thus be transported to lakes in which otherwise no infestation would occur. This may account for the isolated finding made in East Okoboji Lake. What part the migration of infested plankton plays is unknown."

Methods of preparation that prevent infestation.—There is no danger of infestation if fish is properly heated, frozen, smoked, or processed during commercial preparation. Nicholson[30] states that ordinary cooking renders any fish safe. Heating at 65° C. for five minutes kills the larvae, and in ordinary cooking, fish is subjected to 100 degrees or more for at least ten minutes. According to Kajava[14] temperatures of 51° to 53° C. kill the plercercoids. Schor[34] cites 54° to 55° C. for boiling and a temperature of —9° C. for forty-eight hours for freezing. He also reports killing the plerocercoids at —3° to 1° C. at an exposure of at least two days. Hawkins[10] maintains that temperatures 135° to 140° F. (57° to 60° C.) for twenty to thirty minutes destroy the larval stages.

Kajava[14] and Essex and Magath[7] demonstrated that submitting infested fish to a freezing temperature of 14° F. (—10° C.) for from twenty-four to forty-eight hours kills the larvae.

According to Birkeland,[2] larvae seem to thrive when placed in 10 per cent solution of sodium chloride. After forty-eight hours of exposure, even if they are found in a stiff and shrunken condition, they can be revived. In a 15 per cent solution, they are still alive after five hours, and they may still be alive in a 20 per cent solution after one and one-half to two and one-half hours.

Kajava[14] claims that larvae are found dead in well dried and smoked fish, whereas Braun and Seifert[3] and Ward[49] have obtained living plerocercoids from smoked fish. According to Hawkins,[10] smoked and canned fish prepared by commercial fisheries are considered safe as far as infestation is concerned.

Summary.—Thus, a review of the literature definitely indicates that human infestation is due to the ingestion of infested fish that are improperly cooked, insufficiently sun-dried, mildly salted, pickled, smoked, or insufficiently frozen.

Report of Cases

Eleven cases with fish tapeworm infestation have come under our observation since December, 1942. All patients were Jewish women. Five of the wom-

en were patients at North End (Community Chest) Clinic and six were from our private practice. All were born either in Russia or Poland. Ten of the patients have been in this country more than twenty-five years (twenty-five to forty years) prior to passing of fish tapeworm segments; the eleventh case has resided here only eight years.

Four of the patients had mild vague upper abdominal distress for an indefinite period of time. One patient presented an ulcer syndrome, which completely cleared up after passing the head of the worm. Another patient presented "grippe-like" symptoms and diarrhea for twenty-four hours before noting the segments. The remaining five patients were asymptomatic.

The physical examination was essentially negative in each of the patients. The blood picture showed no abnormality other than eosinophilia. The stools presented the typical segments or ova of the Diphyllobothrium latum.

The following history was obtained from each of the eleven patients: During the process of preparing and cooking "gefülte fish," the patients tasted (but did not swallow) a very small portion of the chopped-up fish-muscle or the soup in which it was being cooked. This was done to determine the need for additional seasoning. Invariably, the tasting was done before the dish was brought to a boiling point. All patients were emphatic in the statement that they "spit out" the tasted material and did not swallow it, claiming that they would no more eat raw fish than they would eat raw meat. This was particularly emphasized by one of the patients (the wife of an orthodox rabbi) who stated that eating raw meat or fish is contrary to the Jewish Dietary Laws.

Treatment

Six of the eleven patients were hospitalized and were subjected to a regimen of oleoresin aspidium therapy with successful results. The remaining five cases apparently passed the worm without therapy, since repeated examination of their stools over a a two-year period failed to show either segments or ova or Diphyllobothrium latum.

An outline of the regimen found effective in each of the six cases follows:

1. Each patient was hospitalized for a period of approximately five days.
2. A light bland diet, low in fat, was prescribed for the first two days.
3. On the third day the diet consisted of black coffee, tea and water.
4. At 6:00 p.m. of the third day the patient was given 20 grams of magnesium sulphate dissolved in water.
5. At 6:00 a.m. of the fourth day 20 grams of magnesium sulphate was again given to the patient.
6. No food was allowed on the fourth day.
7. During the morning of the fourth day, after the first bowel movement, 3 grams of oleoresin aspidium were given orally in double sealed capsules. Each double sealed capsule contained 7.5 grains (½ gram) of oleoresin aspidium. One hour later three additional grams of oleoresin aspidium were given in a similar manner.
8. Two hours after the second dose of the drug, 30 grams of magnesium sulphate dissolved in water was taken orally.
9. Two hours later a large soap suds enema was given.
10. The patient was instructed to stay in bed. For her bowel movements she was allowed to sit on a commode containing warm water.
11. All stool speciments were sent to the laboratory for search of the head of the worm.

Comments

Most of the cases of fish tapeworm infestation appearing in the literature are Finns and Jewish women. The mode of infection in the Finns is well known, since a favorite Finnish dish consists of fresh fish soaked in brine for twenty-four hours and then served with green peppers, cabbage and cucumbers. This method of preparation does not kill the plerocercoids. However, in the cases of the Jews, the mode of infestation puzzled most of the early authors, who explained it as due to the "eating of raw fish." Even Warthin,[51] in his 1928 report, attempted to explain the infestation in Jewish women, by claiming: "These patients were all fish-eaters, most of them stating that they preferred uncooked fish." The latter statement is definitely contrary to Jewish customs.

Moses Barron[1] in 1929 was first to explain that infestation in Jewish women occurred while sampling insufficiently cooked fish during the process of preparing "gefülte fish." "It was due to the tendency of the women to taste the raw fish to determine whether the dish was properly seasoned." "In order to make sure of the proper flavor, many housewives are in the habit of tasting the minced raw fish." Since then, most workers have been able to elicit this story from their patients.

From our observations, it appears that infestation with fish tapeworm can occur even if the soup in which infested fish is cooked, is tasted and not swallowed. In preparing "gefülte fish" the fish-muscle is finely chopped and rolled in the skin

of the fish. When the latter is immersed in water for cooking, it is conceivable that the larvae might be freed from the fish preparation.

When soup in which infested fish is being cooked is tasted before adequate boiling, the viable plerocercoids might be deposited in the oral cavity and result in infestation even though the housewife "spits out" the tasted material. As saliva is swallowed later, the plerocercoids may reach the gastrointestinal tract and develop into the adult fish tapeworm. Jewish housewives should be warned against this possible mode of infection.

While only 309 cases (including the eleven herein reported) are recorded in the literature for the United States, and an additional ninety-five cases for Canada, there is no doubt that hundreds, if not thousands, of other individuals in this country were and are infested with fish tapeworm, though their case histories are not recorded in the indexed literature. For example, Warthin,[51] in his 1928 report from the Pathologic Laboratory of the University of Michigan, states: "In the years since 1912, the clinical incidence of the adult tapeworm in native-born human patients has steadily increased, while their incidence in Finns and Swedes who came to this country from the Baltic Region fifteen or twenty years ago, has steadily diminished. Formerly the laboratory came into contact yearly with from one to three cases; in recent years *this incidence has doubled or even trebled.*" On this basis at least 100 Michigan cases must have been observed at the Pathological Laboratory of the University of Michigan since 1912. Yet, a review of all the cases recorded from 1879 to date, discloses only fourteen cases, during the entire sixty-seven-year period, for the whole "endemic" state of Michigan.

Vergeer[40] in 1929, Magath[21] in 1933, and Cushing and Bacal[5] in 1934 discussed the relation of fish tapeworm infestation to the public health and outlined measures of control along the following lines:

1. All sewage should be treated with some killing solution, formaldehyde or chlorine, before being discharged into lakes or streams.
2. People should be taught the necessity for thorough cooking of fish. "Gefülte fish" should not be tasted during preparation for the table.
3. Some system should be inaugurated for reporting human cases of infestation, and isolating the infested person until they are freed of the worm.
4. Freezing methods should be instituted in commercial houses that pack susceptible fish obtained from lakes known to be polluted.
5. Stool of all Baltic immigrants should be examined.
6. Public health authorities should examine samples of possible offending fish, taken from various fish stores, just as is done with milk.
7. Further surveys of lakes and streams should be made in order to discover the extent of infestation of fishes.
8. A campaign should be undertaken to prevent feeding dogs with raw fish of the varieties known to be susceptible to infestation with Diphyllobothrium latum.

The United States Public Health Service[38] replied as follows, when asked about the above measures of control: "The disease is prone to occur in Jews and Scandinavians because of the habits of eating raw fish prepared in traditional manners. The best means of prophylaxis is education of the housewife not to serve dishes prepared with raw fish, not to taste cooking fish, and to cook fish well. I know of no concerted program that has been undertaken to prevent human infections. In fact, any such program should be of a local nature, in areas where the disease is known to be endemic or enzootic. Some of the recommendations (referred by Vergeer and others) would require the expenditure of large sums of money which could not be justified on the basis of 200 (recorded) human cases."

Vergeer and Magath were advised of the views held by the United States Public Health Service. Their statements in answer to the above follow:

Vergeer:[45] "I agree heartily with you that something ought to be done to control the spread of this tapeworm. In addition to education of the public, the United States Public Health Service ought to determine additional sources, sample fish sold in markets or require proper treatment of species known to be infected. I do think that some of the measures that I have suggested as early as 1929 may be somewhat extreme."

Magath:[20] "While I admit that my recommendations for Public Health Control and those required by the United States Public Health Service do not appear to be in agreement, I do not want the reader to think that there was any real antagonism in our viewpoint. The United States Public Health Service is quite right that the problem is not sufficiently great to warrant large expenditures of money to correct, but the treatment of sewage by the application of chlorine is not very expensive and would only have to be done in a few cities in the United States."

It would appear from the above that the following public health measures could be instituted soon

without the expenditure of large sums of money, and with promising results:

1. The development of an educational program by the United States Public Health Service, in cooperation with local public health agencies, to teach housewives not to serve dishes prepared with raw fish, not to taste cooking fish and to cook fish well.

2. Requirement by the United States Public Health Service that fish to be imported into the United States should be subjected first to a freezing temperature of 14 degrees Fahrenheit (—10 degrees Centrigrade) for at least forty-eight hours. (This may well be limited to the species known to be infected, since Vergeer[46] has examined large numbers of all other commercial species of fish from endemic waters and has found them all free from infestation with this tapeworm.)

3. Adequate freezing methods should be required of commercial houses in the United States for susceptible fish obtained from lakes known to be polluted. Commercial packing plants engaged in interstate commerce should be under the jurisdiction of the United States Public Health Service. The remaining plants should be regulated by local public health agencies.

4. Sewage, in the known endemic areas of the United States, should be treated by effective chlorinating processes.

Sewage Disposal in the United States

While this four-point program would tend to control human infestation with fish tapeworm in the United States, it does not take into consideration the more important and more fundamental problem of sewage disposal as it pertains to waterborne diseases in general. For instance, the United States Public Health Service[39] states: "It has been estimated that seventy per cent of sewage in the United States is dumped into surface waters without treatment. In spite of the health hazards involved, the practice has been continued because of the cost of treating sewage. Sewage cannot be treated by chlorination alone because chlorine will not penetrate particulate matter. An effective plant must include settling basins and digestion tanks, followed by the chlorination of the effluent. The cost of such a system is considerable."

As long as water is used as a transportation medium for human or other waste, the problem of sewage disposal will always be present. Efforts should be directed toward removal of a large portion of the settleable solids, harmful organisms and chemical contamination from all sewage before it is disposed into our natural waterways.

The United States Public Health Service, the local public health agencies (state, county and city health departments), the Stream Control Commissions and local Water Board Commissioners have all been more active during recent years in their efforts to eliminate stream pollution, eliminate any body of water that might be health hazards and to make water safe for human consumption and recreational purposes as swimming. However, these agencies are hampered in their efforts "because of the cost of treating sewage" and because "the cost of such a system is considerable." We are confident, however, that were the light of public opinion focused on the facts that "Seventy per cent of sewage in the United States is dumped into surface waters without treatments," and that "In spite of the health hazards involved, the practice has been continued because of the cost of treating sewage," the American public would insist on effective sewage control systems regardless of cost. It is suggested that the American Medical Association take the lead in enlightening the public.*

Summary

1. Eleven cases, all Jewish women, with fish tapeworm infestation, are reported in this communication. The infestation was due to "tasting" of inadequately cooked soup or particles of infested fish and not necessarily to the swallowing of the sampled food. Jewish housewives are in the habit of tasting the soup or particles of the "gefülte" fish (an appetizer) to determine whether the dish is properly seasoned.

2. When soup in which infested fish is being cooked is tasted before adequate boiling, the viable larvae might be deposited in the oral cavity and subsequently swallowed with the saliva, even though the housewife "spits out" the tasted ma-

*The American Medical Association informs us that:

"The sewage of somewhat more than 50 per cent of the total urban population of the United States is now treated, either by what is known as partial treatment or by complete treatment."

"Progress in correcting this situation has been materially retarded during the War period and, in the present high level costs of labor and materials, in the postwar period."

"Administrative attack on the problem, however, continues at a high level, and it may be anticipated that the next ten years will see billions of dollars expended in correcting the situations to which you refer.

"The American Medical Association is cognizant of the practice and is lending its efforts toward increasing the rate of correction. Water-borne diseases in general in the United States are now at their lowest point in our history, as the result obviously of the combined efforts of engineering and medical officials over the last half century."

terial. Housewives should be warned against this possible mode of infection.

3. Infestation with fish tapeworm is most commonly due to the ingestion of infested fish that are improperly cooked, insufficiently sun-dried, mildly salted, pickled or smoked or insufficiently frozen.

4. It is the concensus that to destroy the larvae, the fish must be cooked for approximately one-half hour at a temperature of at least 135° to 140° F. (57° to 60° C.) or frozen for from twenty-four to forty-eight hours at a temperature of 14° F. (—10° C.).

5. The following fish in the United States *have been definitely shown* to harbor live plerocercoids: great northern pike, wall-eyed pike, sand pike, burbot and yellow perch. The only other species of fish, *suspected* of being a host, is Pacific (Alaskan) salmon and landlocked eastern salmon.

6. Three hundred and ninety-three cases with fish tapeworm infestation were recorded in the literature to date for the United States and Canada. With the eleven cases comprising our report, the series is increased to 404. Of these, 309 patients are from the United States (259 foreign born cases and fifty native cases) and ninety-five from Canada (seventy-two foreign born and twenty-three native Canadians).

7. Since fish tapeworm infestation is not a reportable disease, the exact incidence of this disease for the United States is not known. However, there is no doubt that many hundreds, if not thousands, of individuals in this country were and are infested with fish tapeworm, though their case histories are not recorded in the indexed literature.

8. Public health measures of control are outlined. These are:

(A) Educational programs for housewives not to serve dishes prepared with raw fish, not to taste cooking fish (or soup in which fish is being cooked) and to cook fish well.

(B) Requirement by the United States Public Health Service that fish imported into the United States (particularly the species known to be infested) should first be subjected to adequate freezing;

(C) Adequate freezing methods should be instituted in United States' commercial houses that pack susceptible fish obtained from lakes known to be polluted; and

(D) Sewage in the known endemic areas of the United States should be treated by the application of chlorine.

9. The problem of sewage disposal as it pertains to water-borne diseases in this country is discussed. It is recommended that an effective program of sewage control be implemented regardless of the cost involved, since the present method in the United States of dumping much of the sewage into surface waters without treatment involves definite health hazards.

Addendum: While this paper was in press, another patient (the twelfth of our series) came under observation with fish tapeworm infestation. The patient is a Jewish woman who was born in Poland and who has been in this country during the last ten years. The history of this case was similar to those described in the body of this paper.

References

1. Barron, Moses: Infestation with Diphyllobothrium latum, fish tapeworm, with especial reference to native cases. J.A.M.A., 92:1587-1593, (May 11) 1929.
2. Birkeland, I. W.: Bothriocephalus anemia. Medicine, 11:1-139, (Feb.) 1932.
3. Braun, M., and Seifert, O.: Die Tierischen Parasiten des Menschen. Ed. 5, Wurzburg: Curt Kabitzsch, 1:559, 1915. Also Die Tierischen Parasiten des Menschen. Ed. 2. Leipzig: Curt Kabitzsch, 2:506, 1920.
4. Canavan, W. P. N.: Spread of broad fish tapeworm of man. Science, 75:337, (Mar.) 1932.
5. Cushing, H. B., and Bacal, H. L.: Diphyllobothrium latum infestation in Eastern Canada. Canad. M. A. J., 30:377-384, (Apr.) 1934.
6. Essex, H. E.: Early development of Diphyllobothrium latum in northern Minnesota. J. Parasitol., 14:106-109, (Dec.) 1927.
7. Essex, H. E., and Magath, T. B.: A comparison of the viability of ova of the broad fish tapeworm Diphyllobothrium latum, from man and dogs: Its bearing on the spread of infestation with this parasite. Am. J. Hygiene, 14:698, 1931.
8. Faust, E. C.; Craig, C. F., and Faust, E. C.: Clin. Parasitology, 431-437, 1937.
9. Hamilton, W. F.: A specimen of Bothriocephalus latus. Montreal M. J., 30:350-351, (May) 1901.
10. Hawkins, P. A.: Personal communication, (Oct. 2) 1946.
11. Headlee, W. H.; Kmecza, J. M., and Cable, R. M.: Report of a native case of infection by the fish tapeworm. Diphyllobothrium latum. Indiana State M. A., 32:188-189, (Apr.) 1939.
12. Hunnicutt, T. N.: An anemia associated with a fish tapeworm (Diphyllobothrium latum) infestation. J.A.M.A., 104: 1984-1986, (June 1) 1935.
13. Ingall, M., and Freeman, H.: The prevalence of tapeworm infestation in Jewish patients. New England J. Med., 202: 679-681, (Apr. 3) 1930.
14. Kajava, Y.: Nagra iakttagelser rorande den breda bandmaskens (Bothriocephalus latus) blasmask. Finska La.-Sallsk. Handl., 1:700-707, 1913.
15. Leidy: On Bothriocephalus latus. Proc. Acad. Nat. Soc., 31:40, 1879.
16. Levy, D. J., and Pierson, M.: Native infestation by fish tapeworm, Diphyllobothrium latum. J.A.M.A., 87:848, (Sept. 11) 1926.
17. Lyon, M. W.: Native case of infestation by fish tapeworm, Diphyllobothrium latum. J.A.M.A., 86:264:265, (Jan. 23) 1926.
18. Lyon, M. W.: The fish tapeworm and its occurrence in Indiana. Indiana State M. A., 23:72-75, (Feb.) 1930.
19. Magath, T. B.: Experimental studies on Diphyllobothrium latum: Preliminary report. Proc. Staff Meet. Mayo Clin., 2:169-171, (Aug. 3) 1927; Experimental studies on Diphyllobothrium latum. Minnesota Med., 10:614-616, (Oct.) 1927.
20. Magath, T. B.: Personal communication, (Nov. 14) 1946.
21. Magath, T. B.: The relation of Diphyllobothrium latum infestation to the Public Health. J.A.M.A., 101:337-341, (July 29) 1933.
22. Magath, T. B., and Essex, H. E.: Concerning the distribution of Dopryllobothrium latum in North America. J. Prev. Med. 5:227-242, 1931.
23. McClure, W. B., and Teskey, L.: A case of infestation with

Diphyllobotbrium latum. Canad. M. A. J., 31:64-65, (July) 1934.
24. McGarvan, E. G., and Songklā, M.: Diphyllobothrium latum in Massachusetts. J.A.M.A., 90:1607-1608, (May 19) 1928.
25. Muntz, H. J.; Headlee, W. H., and Ritchey, J. O.: Fish tapeworm. Quart. Bull. Indiana Univ. M. Center, 7:12-17, (Jan.) 1945.
26. Myers, T.: Fish tapeworm infestation in children. Arch. Pediat., 47:609-614, (Oct.) 1930.
27. National Research Council: Manual of Tropical Medicine. p. 420. Philadelphia: W. B. Saunders Co., 1945.
28. Nickerson, W. S.: The broad tapeworm in Minnesota, with the report of a case of infection acquired in the state. J.A.M.A., 46:711-713, (March 10) 1906.
29. Nicholson, D.: Fish tapeworm: Intestinal infection in man: the infestation of fish in Manitoba Lakes. Canad. M.A.J., 19:25-33, (July) 1928.
30. Nicholson, D.: Variations in the fish larvae of Diphyllobothrium latum. Canad. Pub. Health J., 20:193-195, (Apr.) 1929.
31. Pilot, I., and Levin, J. M.: Native infestation with Diphyllobothrium latum. Am. J. M. Sc., 181:710 (May) 1931.
32. Plotz, M.: Diphyllobothrium latum infestation in the eastern seaboard: Twenty-one cases from New York, J.A.M.A., 98: 312, (Jan. 23) 1932.
33. Ronka, E. K. F.: Infestation with Diphyllobothrium latum. New England J. Med., 210:582-583, (Mar. 15) 1934.
34. Schor: Quoted by Braun and Seifert.[3]
35. Stiles, C. W.: Intestinal taeniasis. Tapeworm infestation. In: Osler, Williams: Modern Medicine. Ed. 2. Philadelphia: Lea Brothers and Company, 1:567-568, 1907.
36. Summers, W. A., and Weinstein, P. P.: Diphyllobothrium latum in Florida. Am. J. Trop. Med., 23:363-367, (May) 1943.
37. Sunkes, E. J., and Sellers, T. F.: Tapeworm infestation in southern United States. Am. J. Pub. Health, 27:893-898, (Sept.) 1937.
38. U. S. Public Health Service: Personal communication, (Oct. 9) 1946.
39. U. S. Public Health Service: Personal communication, (Nov. 29) 1946.
40. Vergeer, T.: Broad tapeworm in America with suggestions for its control. J. Infect. Dis., 44:1-11, (Jan.) 1929.
41. Vergeer, T.: Canadian fish, a source of the broad tapeworm of men in the United States. J.A.M.A., 90:1687-1688, (May 26) 1928.
42. Vergeer, T.: Causes underlying increased incidence of broad tapeworm in man in North America. J.A.M.A., 95: 1579-1581, (Nov. 22) 1930.
43. Vergeer, T.: Diphyllobothrium latum (Linn. 1758). The broad tapeworm of man: Experimental studies. J.A.M.A., 90:673-678, (Mar. 3) 1928.
44. Vergeer, T.: New sources of broad tapeworm infestation. Report of fourteenth native case. J.A.M.A., 91:396-397, 1928.
45. Vergeer, T.: Personal communication, (Nov. 16) 1946.
46. Vergeer, T.: Personal communication, (Dec. 2) 1946.
47. Vergeer, T.: The dog a reservoir of the broad tapeworm. J.A.M.A., 92:607-608, (Feb. 23) 1929.
48. Walker, J. T.: Bothriocephalus latus. Philadelphia Med. Times, 9:326,1879.
49. Ward, H. B.: Animal parasites. In Abst., IA: Pediatrics, 8:1004-1010, 1926.
50. Ward: Quoted by Magath, T. B.[21]
51. Warthin, A. S.: Increasing human incidence of broad tapeworm infestation in Great Lakes Region. J.A.M.A., 90:2080-2082, (June 30) 1928.
52. Waters, H. S., and O'Connor, F. W.: Diphyllobothrium latum. Sources of native infestation in New York City, J.A.M.A., 99:1941, (Dec. 3) 1932.

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4. Hertz, A. F.: The cause and treatment of certain unfavorable after-effects of gastroenterostomy. Ann. Surg., 5:466-472, 1913.
5. Kennedy, C. S.; Reynolds, R. P., and Cantor, M. O.: A study of the gastric stoma after partial gastrectomy. Surgery, 22:41-47, (July) 1947.
6. Kennedy, C. S.; Reynolds, R. P., and Cantor, M. O.: Clinical demonstration of sphincteric action at the true gastric stoma. Accepted for publication: Am. J. Surg., (Aug.) 1946.
7. Kennedy, C. S.; Reynolds, R. P., and Cantor, M. O.: Does a sphincter develop after partial gastrectomy? Presented before American College of Surgeons, Sept. 8, 1947.
8. Miller, G. G.: Discussion in article of Allen, A. W., and Welch, C. E.: Ann. Surg., 124:688-703, (Oct.) 1946.
9. Pendergrass, E. P.; Ravdin, I. S.; Johnston, C. G., and Hodes, P. J.: Studies of the small intestine. Radiology, 26: 651-662, (June) 1936.
10. Ravdin, L. S.; Pendergrass, E. P.; Johnston, C. G., and Hodes, P. J.: The effect of foodstuffs on the emptying of the normal and operated stomach and small intestional pattern. Am. J. Roentgenol., 35:306-315, (Mar.) 1936.

Treatment of Motion Sickness

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FOR CENTURIES man has been confronted with the baffling problem of prevention and treatment of motion sickness. As in modern times, even the Romans and Greeks found that military engagements were frequently endangered if not lost by widespread seasickness. World War II necessitated the movement of unaccustomed troops traveling unexpectedly not only on the sea, but in the air and on unusual land conveyances. For this reason American and British investigators have studied the problem of motion sickness exhaustively.[1-5]

Cessation of military hostilities has not decreased the importance of this disease syndrome. The impetus to travel, particularly in the air, resulting from war experience, makes prevention and treatment of motion sickness a timely subject.

In recent years aircraft have undergone many changes toward mechanical perfection. The improvements in many instances tax the balance of human physiology. Tremendously large steamships on the seas tend to minimize motion, hence, reduce the incidence of illness aboard these vessels. Long flights in the stratosphere, whenever this method of travel becomes available, will undoubtedly decrease airsickness. This mode of travel will always be in the minority because it is not feasible to attain great heights to traverse relatively short distances.

Accurate statistics on the incidence of motion sickness among civilians are not available. Data from military sources probably do not reveal a true rate for the reason that observations include almost exclusively the male sex of a select group and that most individuals are reluctant to admit to motion sickness in its milder aspects. Schwab[11] states that 40 per cent of any population is sus-

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ceptible to seasickness, and Lilienthal[8] reports two classes of Navy personnel, "those who have experienced motion sickness and those who will not admit it." It is generally agreed that most unconditioned persons are susceptible to motion sickness in its various degrees.

Commercial airlines are faced with the problem of airsickness as a major obstacle. The incidence of passengers suffering from motion sickness cannot be minimized. Flights are not easily terminated and present methods of prophylaxis and treatment are inadequate. Transcontinental and oceanic air passage have ended not infrequently with prostrated travelers.

Motion sickness of many types is encountered. Most common are those observed in connection with travel on the sea (seasickness); in the air (airsickness), and in trains and automobiles on land (landsickness). Swings and various amusement park devices may cause the familiar syndrome. Riding of animals, particularly camels, not infrequently produces symptoms.[4]

The etiology of travel sickness has tested the ingenuity of investigators for ages. The illness is most often seen in susceptible individuals with hypersensitivity of the vegetative nervous system. Of the many factors involved, most are related to psychological, physiological and mechanical stimuli. Females are more susceptible to motion sickness than males, and children, especially infants, and the aged are usually immune.

World War II experiences definitely showed the psychic factor played the largest role in motion sickness. Schwab found approximately 75 per cent of those individuals suffering from chronic seasickness to have neurotic tendencies.[11]

The picture of the air traveler making his first flight is a familiar one. The individual is tense; he is anxious; he smokes tobacco continuously. There is the roar of engines, new faces, the sensations never before experienced while in flight. As the result of the aforementioned stimuli, the passenger has symptoms of pylorospasm and other reactions of the autonomatic nervous system in response to fear and anxiety.

Abnormal stimulation of the endolymph of the semi-circular canals of the inner ear has long been known to produce the effects frequently encountered in motion sickness. It has been said that the individuals who have a non-functioning labyrinth, deaf mutes, never are affected by travel illness. The turbulence of air and water motion causes alternate flow in the semi-circular canals to produce the syndrome. Similar results may be obtained by syringing of the external ear canal as performed in caloric ear tests. Indeed, motion sickness prophylaxis may be obtained by increasing one's tolerance to caloric tests. Likewise, swings and rotating chairs may be used to lessen the susceptibility to travel sickness.

Other sources of stimuli may come from the olfactory nerve. Sickness may be precipitated by unusual fumes or odors that emanate from electrical devices, motors or food. The sudden onset of nausea and vomiting when the passenger is confronted with already ill travelers is not uncommon. Over-indulgence in rich food, overloading the gastrointestinal tract, or the excessive use of alcohol may lessen the resistance of the experienced traveler.

Poor ventilation with associated increase in temperature predisposes to travel illness. In many individuals the precipitating stimuli may be the rapid movement of objects such as passing of a long train of cars on another track.

The symptoms of motion sickness may vary from slight anorexia to food or tobacco, to severe prostration. The traveler notes loss of interest followed by increased salivation, pallor, and sweating. Vertigo is usually sudden, and nausea with headache soon appears. The aforementioned sequence procedes the prolonged vomiting and retching and subsequent prostration seen in severe cases. In a group of sailors suffering from chronic seasickness, 50 per cent were found to exhibit abnormal gastrointestinal findings on barium studies. Irritability of the pylorus and duodenum with spasm were noted, as well as increased gastric secretions, increased gastric rugae and loss of normal peristalsis. Gastroscopic examination revealed mild chronic superficial gastritis in fifteen of 115 subjects studied.[11]

Hundreds of medicinal preparations have been tried to prevent or treat the discomfort of motion sickness. Rituals lasting several days were thought to be specific many years ago in preventing the disease. In more recent times ingestion of barbiturates, atropine compounds, strychnine, benzedrine, ergotrate, hyoscine, et cetera, have been utilized. Holling, McArdle, and Trotter[7] in a critical study of thirteen compounds found that hyoscine was far superior in many respects to the other drugs tested. Others have similarly described hyoscine as the

TABLE I. TREATMENT OF SEASICKNESS WITH CHEWING GUM MEDICATED WITH HYOSCINE AND ACETYLSALICYLIC ACID

			Previous History					Symptoms				Other Medication		Motion Sickness Gum			
	Age	Sex	Air	Sea	Car	Train	Swing	Nausea	Dizziness	Vomiting	Prostration	Type	Result	Dryness	Blurring	Flushing	Result
T. J.	39	F	0	?	0	0	0	2+	+	0	0			0	0	0	Complete relief
A. S.	52	F	x	x	x	x	?	4+	4+	0	2+			0	0	0	Complete relief
M. S.	45	F	0	0	0	0	0	3+	2+	2+	+	Chloretone Gr. 15 Phenobarb. Gr. 1	No relief				
A. W.	66	M	0	x	0	0	0	2+	+	0	0			0	0	0	Complete relief
B. W.	51	F	0	?	0	0	0	4+	4+	2+	2+			0	0	0	Complete relief
F. E.	58	M	0	0	0	0	0	3+	+	0	0	Chloretone Gr. 15	Poor relief	sl.	0	0	Fair relief
A. E.	52	F	0	0	0	0	0	3+	+	2+	2+	Chloretone Gr. 15 Phenobarb. Gr. 1	No relief	0	0	0	Fair relief
E. W.	30	F	0	?	0	0	0	3+	2+	2+	+			0	0	sl.	Complete relief
B. S.	47	F	0	x	0	0	0	4+	4+	4+	4+	Phenobarb. Gr. 1	?	sl.	0	sl.	Good relief
C. S.	51	M	0	0	0	0	0	4+	4+	0	?	Phenobarb. Gr. 1	Good relief				
W. J.	43	M	0	x	0	0	0	2+	+	0	+	Chloretone Gr. 15	No relief	0	0	0	Complete relief
A. G.	46	M	0	?	0	0	0	2+	+	0	+	Chloretone Gr. 15	Good relief				
S. G.	45	F	0	0	0	0	0	2+	4+	0	4+	Chloretone Gr. 15 Phenobarb. Gr. 1	Fair relief				
W. B.	44	M	0	x	0	0	0	3+	+	0	0			0	0	0	Complete relief
M. L.	50	F	0	x	0	0	0	4+	2+	2+	2+			0	0	0	Good relief
G. L.	50	M	0	0	0	0	0	2+	2+	0	?			0	0	0	Good relief
S. W.	26	F	0	0	0	0	0	2+	2+	0	4+	Chloretone Gr. 15 Phenobarb. Gr. 1	Good relief				
W. P.	36	M	0	x	0	0	0	2+	2+	0	0	Chloretone Gr. 15	No relief	0	0	0	Complete relief
B. G.	29	F	0	0	0	0	0	4+	4+	0	4+	Chloretone Gr. 15 Phenobarb. Gr. 1	Vomited	sl.	0	sl.	Fair relief
G. S.	33	F	0	x	0	0	0	2+	+	+	0			0	0	0	Complete relief
B. S.	33	M	0	x	0	0	0	2+	+	+	0			0	0	0	Fair relief
A. I.	21	F	0	x	x	0	0	2+	+	2+	0			0	0	0	Good relief
O. N.	16	F	0	x	0	0	0	2+	+	2+	0			0	0	0	Good relief
R. N.	46	F	0	x	0	0	0	2+	+	2+	0			0	0	0	Complete relief
A. L.	42	F	0	x	0	0	0	2+	+	+	0			0	0	0	Complete relief
L. O.	60	F	0	x	0	0	0	2+	+	4+	0			0	0	0	Complete relief
V. B.	32	F	0	x	0	0	0	4+	+	2+	0			0	0	sl.	Complete relief
S. H.	24	F	0	x	0	0	0	3+	+	2+	0			0	0	0	Complete relief
O. B.	12	M	0	0	0	0	0	2+	+	+	+	Phenobarb. Gr. 1	No relief	0	0	0	Complete relief
R. D.	28	M	0	x	0	0	0	2+	2+	+	0			sl.	0	0	Good relief
L. S.	32	F	0	x	0	x	x	4+	3+	4+	2+	Phenobarb. Gr. 1	No relief	0	0	0	Good relief

most effective medicinal for prevention of motion sickness.[2,9,10]

The mode of action in which hyoscine protects against travel sickness is unknown. Observations have repeatedly demonstrated the drug as an anticholingeric agent. On the central nervous system its action is that of a sedative as is so often seen in the management of obstetrical cases. Hyoscine is rapidly absorbed not only in the stomach but through the mucous membranes of the mouth. In the prophylaxis of motion sickness the drug has been given in doses ranging from 1/100 gr. (0.06 mg.) to 1/400 gr. (0.015 mg.) without undesirable side effects. Hyoscine (scopolamine) has been used for many years in obstetrical care in doses as large as 1/50 gr. (0.12 mg.). Prostigmine has a pharmacologic action opposite to that of hyoscine and may be used to counteract its effect. Hyoscine produces an atropine-like effect in its vagal action and causes dryness of the mouth and dilatation of the pupils. Decreased perspiration as a result of this medication has never proved troublesome even in the tropics.[6] Other symptoms of mild light-headedness, flushing, and slight sleepiness appear only in a small percentage of individuals. None of the above side effects interfered in any manner in the highly technical task of flying combat aircraft. Lilienthal, using hyoscine in 1/100 gr. doses repeated once, found dryness of the mouth to be the most common side effect, occurring in 12.5 per cent of the individuals. In his study the attack rate of airsickness in pilots was 7.53 in the control group, 6.28 when a placebo was given, and but 0.50 upon the administration of hyoscine.[9]

Hyoscine hydrobromide 1/400 gr. has been combined with acetylsalicylic acid 3½ gr. in coated chewing gum tablets.* The beneficial effects of chewing gum upon the eustachian tube, internal ear, and paranasal sinuses have been observed for years to be of considerable aid in maintaining equalized pressures between these organs in airborne travelers. The use of medicated chewing gum obviated the embarassment which some individuals

*Material for this study (Trip-Eze) supplied by Multiproducts Company, Inc., Washington, D. C.

TABLE II. TREATMENT OF CARSICKNESS WITH CHEWING GUM MEDICATED WITH HYOSCINE AND ACETYLSALICYLIC ACID.

			Previous History					Symptoms				Motion Sickness Gum			
	Age	Sex	Air	Sea	Car	Train	Swing	Nausea	Dizziness	Vomiting	Prostration	Dryness	Blurring	Flushing	Result
*G. D.	10	M	0	x	x	0	x	0	0	0	0	0	0	0	No sickness
W. G.	7	F	0	x	x	0	0	3+	0	2+	0	0	0	0	Complete relief
O. D.	28	F	0	x	x	x	0	2+	2+	0	0	0	0	0	Complete relief
*J. S.	11	F	0	0	x	x	x	0	0	0	0	0	0	0	No sickness
*T. J.	21	F	0	0	x	x	0	0	0	0	0	0	0	0	No sickness
A. D.	15	F	0	x	x	0	x	2+	1+	0	0	0	0	0	Good relief
*A. L.	31	F	0	x	x	x	0	0	0	0	0	0	0	0	No sickness
R. P.	35	F	x	x	x	0	0	3x	x	0	0	0	0	0	Complete relief

*Prophylaxis.

TABLE III. TREATMENT OF AIRSICKNESS WITH CHEWING GUM MEDICATED WITH HYOSCINE AND ACETYLSALICYLIC ACID.

			Previous History					Symptoms				Motion Sickness Gum			
	Age	Sex	Air	Sea	Car	Train	Swing	Nausea	Dizziness	Vomiting	Prostration	Dryness	Blurring	Flushing	Result
*B. D.	38	F	x	x	0	0	0	0	0	0	0	0	0	0	No sickness
*V. D.	42	F	x	x	0	0	0	0	0	0	0	sl.	0	0	No sickness
*R. B.	24	M	x	x	0	0	x	0	0	0	0	0	0	0	No sickness
*R. M.	14	M	x	x	0	0	0	0	0	0	0	0	0	0	No sickness
*A. R.	51	F	x	x	0	0	x	0	0	0	0	0	0	0	No sickness
*T. A.	33	F	x	0	0	0	x	0	0	0	0	sl.	0	0	No sickness
R. L.	55	M	x	x	0	0	0	2x	xx	0	0	0	0	0	Complete relief
*M. B.	28	F	x	x	0	0	x	0	0	0	0	0	0	0	No sickness
O. T.	32	F	x	x	x	0	0	3x	2x	2x	0	0	0	0	Complete relief
F. K.	45	M	x	x	0	0	0	2x	0	1x	0	0	0	0	Good relief

* Prophylaxis.

suffer when taking "pills" in public. Absorption of the drug through the mucous membranes of the mouth is particularly advantageous in the presence of nausea or vomiting. The psychological benefits to be derived by chewing cannot be overlooked. In air travel, smoking of tobacco during take-off and landing is prohibited because of fire hazard. It is at these times that chewing gum acts specifically to equalize the paranasal pressure and reduce nervous tension so often associated with these critical moments of air travel.

Hyoscine is combined with acetylsalicylic acid for synergistic action and its analgesic effects against nervous tension symptoms.

Infants and young children infrequently suffer from travel sickness. The recommended dosage for older children (ages seven to fourteen years) for prophylaxis is one medicated tablet one hour before departure. If necessary this dosage may be repeated in four hours. Total dosage should not exceed three tablets in twenty-four hours. Comparable doses may be given in the treatment of motion sickness. Adults obtain best results for prophylaxis when one tablet of gum is chewed one hour before departure and repeated at the time of departure. A third tablet can be chewed one hour after departure and successive doses can be taken at two-hour intervals not to exceed five tablets in a twenty-four-hour period. Treatment, once symptoms appear, can be given on a similar schedule.

In individuals who experience the side effects of hyoscine, further dosage should be deferred until the symptoms of dryness of the mouth, blurring of vision, et cetera, disappear.

As previously discussed, the protection against motion sickness by hyoscine has been well established. Fewer statistics and observations are available in the treatment of travel illness in an active form. Table I represents a study of in-

dividuals who became seasick while traveling on passenger boats on the Great Lakes. The data was obtained by unbiased and well-trained physicians. In several instances chloretone and phenobarbital were used unsuccessfully, only to be followed by good results after medicated chewing gum. Admittedly the statistics are incomplete in that many variables are in operation. One can conclude that the hyoscine gum preparation is effective in the treatment of seasickness, and appears in some cases to benefit individuals in whom chloretone and phenobarbital did not give relief. A previous experience with a belladonna and phenobarbital oral mixture was disappointing.

Table II illustrates the results obtained in the treatment of carsickness, and Table III, airsickness, with medicated chewing gum.

Certain precautions can be taken by individuals susceptible to motion sickness for prevention of the illness. Overloading of the gastrointestinal tract with food and alcoholic drink is one of the commonest predisposing factors to travel illness. Frequent small meals are advisable; fatty foods are to be avoided because of slow digestion of this type of food. Tendency to constipation should be avoided; mild cathartics may be used to obviate this situation. Even experienced travelers will be made ill by overindulgence in alcoholic beverages. The resultant gastritis, pylorospasm, and bowel irritation acts as a trigger mechanism.

Proper seating of passengers can be utilized to lessen the incidence to susceptible travelers. Individuals at or near the center of gravity of the vehicle experience less motion and labyrinth stimulation. Air travelers will find least motion at the wings, particularly the edge nearest the nose of the airplane. Train occupants find motion at a minimum in the center of the car, while least motion is experienced in the front seat of an automobile. Aboard ship, the lower deck inside cabin amidship offers the best site of protection.

Most individuals find the reclining position gives relief from early symptoms in motion sickness. This is accomplished by change of the planes of the labyrinth canals. Sea passengers have found that illness may be prevented by assuming positions aboard ship in relation to the motion of the boat and position of canal systems. Swaying against roll of the ship aids in reducing stimulation. One should avoid sudden movement such as rising in a hurry, bending the head, et cetera.

An explanation of the psychic component is of help to nervous susceptible passengers. Nervous relaxation, mild exercise, and time-consuming activity are to be advised. Good ventilation which insures cool fresh air is helpful.

It has been long observed that co-ordination of the visual proprioceptive and labyrinth systems is essential. Fixing the eyes on distant objects, such as the horizon, facilitates this sensory integration. Observance of rapidly passing close objects produces disorientation which is usually followed by motion sickness symptoms.

Summary

1. The incidence of motion sickness in modern methods of travel is sufficient to warrant serious consideration both as to prophylaxis and treatment.

2. Multiple stimuli of psychologic, physiologic, and mechanical origin act upon susceptible individuals to produce travel sickness.

3. The syndrome of motion sickness is described and various methods of prophylaxis and treatment are discussed.

4. Hyoscine hydrobromide has been found to be the most effective anti-motion sickness medication. When this drug is combined with acetylsalicylic acid in a chewing gum base, the resultant combination affords a most satisfactory therapeutic agent in prophylaxis and treatment of motion sickness.

References

1. Agin, L. J., and others: Airsickness and related psychosomatic complaints. Air Surgeon's Bull., 2:235-236, (Aug.) 1945.
2. Critical study of seasickness remedies. Roy. Nav. Med. Bull. No. 4, pp. 3-6, 1943. Abst., Bull. War Med., 4:306-307, (Jan.) 1944.
3. Hemingway, A.: Selection of men for aeronautical training based on susceptibility to motion sickness. J. Aviation Med., 17:153-163, (April) 1946.
4. Hemingway, A.: The relationship of air sickness to other types of motion sickness. J. Aviation Med., 17:80-85, (Feb.) 1946.
5. Hemingway, A., and Green, E. L.: Airsickness during early flying training. J. Aviation Med., 16:409-16, (Dec.) 1945.
6. Hill, I. G. W., and Guest, A. I.: Prevention of seasickness in assault craft; report of experiments under tropical conditions. Brit. M. J., 2:6-11, (July 7) 1945.
7. Holling, H. E.; McArdle, B., and Trotter, W. R.: Prevention of seasickness by drugs. Lancet, 1:126-129, (Jan. 22) 1944.
8. Lilienthal, J. L., Jr.: Contact, 2:120, 1943.
9. Lilienthal, J. L., Jr.: Effect of hyoscine on airsickness. J. Aviation Med., 16:59-68, (April) 1945.
10. McNally, W. J., and Stuart, E. A.: Physiology of labyrinth reviewed in relation to seasickness and other forms of motion sickness. War Med., 2:683-771, (Sept.) 1942.
11. Schwab, R. S.: Chronic seasickness: neurologic, psychiatric and naval aspects. U. S. Nav. M. Bull., 40:923-936, (Oct.) 1942.

MSMS

The Council on Medical Service of the American Medical Association reports that 5,000,000 persons are covered by medical society approved prepayment medical care plans.

Subclinical Hypo-Ovarianism

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THE GENERAL practitioner who is interested in endocrinology is in a peculiar position. He has the advantage of seeing the patient before a diagnosis is made and to him goes the satisfaction of discovery of an endocrinopathy. Yet he is at a great disadvantage when it comes to making an exhaustive scientific study of his many cases. He is usually neither trained nor equipped to make such studies as determination of 17-ketosteroid excretions or endometrial biopsies. Many of his observations are, therefore, lost because his findings are not sufficiently well organized to be worthy of publication.

This paper is an attempt on the part of one general practitioner to bring up certain observations and conclusions drawn therefrom. It is a study of 123 cases of hypo-ovarianism seen in the last two years. They have been followed as only a small-town general practitioner can do—not only by seeing patients in the office but also in curbstone consultations with members of the immediate family.

This is an empirical study based on inductive rather than deductive reasoning. It began with a general belief; later, cases were found which support this belief.

The original belief was that estrogen deficiency is more common than ordinarily suspected; that there is a syndrome which may be called subclinical estrogen deficiency. It was further believed that the degree of deficiency can be slight enough to be undetectable by available laboratory procedure, yet of sufficient severity to prevent the patient from enjoying the good health she deserves.

In an uncontrolled study such as this, numerous objections might be raised as to the validity of the diagnosis and the accuracy of the observations. It is freely admitted such objections are justifiable. Yet, in order to have a reasonable foundation for further discussion of these cases, the following postulates are assumed:

1. If a patient has symptoms suggestive of ovarian deficiency, and if she is relieved of these symptoms following the administration of estrogen alone, such a response confirms a presumptive diagnosis of estrogen deficiency.
2. If such a patient who is relieved by estrogen therapy notices recurrence of her difficulties on withdrawal of estrogen, and is again relieved by renewed administration of estrogen, the diagnosis is further sustained.

This series of cases includes only women who were relieved of their original complaints by taking estrogen—in other words, women who had hypo-ovarianism as defined in the above paragraphs. It seems pertinent to remark that while it might be inaccurate to draw a conclusion from ten cases or so, a series of over 100 cases should come close to proving one's point.

The following criteria, therefore, were adopted as being sufficient to give rise to a suspicion of estrogen deficiency:

1. Subjective nervousness.
2. Irritability. That is most often manifested by such statements as: "The children get on my nerves something terrible."
3. Depression, melancholy or actual episodes of weeping; any or all of these brought on without good reason.
4. Pain in the back of the neck and across the trapezius muscles; cervical myalgia.
5. Sensation of inward nervousness in the epigastrium, vulgarly described as "butterflies in the belly."
6. Numbness and tingling of the extremities. The patient will often report that her arms or legs "go to sleep" easily.
7. Fatigability and loss of ambition.
8. Dizziness.
9. Alteration of menstruation from the arbitrary normal of a twenty-eight cycle and a five-day flow.

The usual procedure in obtaining a history follows: The patient would present one or two complaints such as dizziness and fatigability. If, after further questioning, sufficient other complaints in the foregoing list could be elicited, she was assumed to have an estrogen deficiency and administration of estrogen was considered. If, further, some of the signs of estrogen deficiency were seen, estrogenic therapy was instituted.

It has been observed that there are several signs of estrogen deficiency which apparently have not been stressed in the literature. They are as follows:

Sallow skin.—This is a peculiar café-au-lait coloration in which the skin seems to lose its normal translucency; the skin bears a closer resemblance to a muddy river than to a clear brook. The typical example of this coloration is seen in the woman who is having an uncomfortable time during pregnancy. This sign is almost pathognomonic; one can frequently see a new patient in his waiting room and make the diagnosis of ovarian deficiency before she enters his office where the diagnosis is confirmed.

Stratification of the fingernails.—In this the fingernails break easily but they break in layers parallel with the plane of the nail. This type of nail breaking should be contrasted with the dry, brittle nails of the thyroid-deficient patient which break straight across.

Sighing respiration.—This is supposed to be a sign of "nervous exhaustion" or a manifestation of psychoneurosis. Nevertheless, it often disappears on administration of estrogen.

Concavity of the lateral aspect of the buttock.—This occurs directly posterior to the greater trochanter and overlies the insertion of the gluteus maximus. The usual hypo-ovarian patient is, of course, obese and has the characteristic trochanteric fat pads. As one patient expressed it: "She looks as if she were wearing riding breeches under her skin." In the thin patient with ovarian deficiency this fat pad is lost and instead we see the convacity mentioned, giving to the buttock a male, rather than a female appearance.

Etiology

An attempt was made in each case to determine the etiology of the estrogen deficiency. Probable causes included the following:

1. Menopause.

2. Oöphorectomy. Frequently patients who have one ovary surgically removed will show signs of ovarian deficiency within five years after surgery.

3. Hysterectomy. Although this causes the menopause, it should not, theoretically, cause a disturbance in the function of the ovaries, yet most women who have the uteri removed will show symptoms typical of the climacteric.

4. Pregnancy. An ideally pregnant woman should have a clear, glowing skin and should look and feel as though she were in the best of health. Not, infrequently, however, we see the opposite extreme where the patient has the sallow skin, fatigability, lassitude and the general appearance of one whose state of health is a great burden.

TABLE I

Number patients improved	83	Per cent improved	68.6%
Number patients controlled	38	Per cent controlled	31.4%

5. Late puerperium. Occasionally a mother, two to six months after the birth of the baby, will report symptoms suggestive of ovarian deficiency. Very often the complaint that brings her to the doctor is loss of libido.

6. Emotional stress. It is a well-known fact that various types of emotional stress can cause glandular upsets. The classic example of this is the young unmarried girl who has indulged in sexual indiscretion and misses her next menstrual period, not because she is pregnant, but because her emotions of fear and guilt have depressed her ovarian function enough to cause amenorrhea. Apparently emotional stress over a long period, what might be called a chronic state of unhappiness, will also cause a deficiency in ovarian function.

7. Heredity. It is apparently possible for a girl to inherit a glandular pattern, especially a deficiency pattern. On several occasions a mother and two daughters have all been seen with the same type of ovarian deficiency. Perhaps the theory of fetal exhaustion of endocrine glands is the explanation for this phenomenon. The possibility of inheritance of a glandular pattern might also explain the obesity which is obviously familial. A child is fat not because his parents are fat but because he has inherited a glandular pattern which tends to make obesity easier to acquire.

8. Constitutional defects. Some individuals seem to be in that sad state wherein the endocrine glands given to them prenatally are just not of good quality. The work of Ivy and his associates on the depression of gonadal structure and function in the offspring of the mother who has been given large doses of androgen or estrogen might explain

this. We have all seen boys, sons of mildy effeminate fathers and very feminine mothers, turn out to be definitely effeminate, with such stigmata as gynecomastia and high-pitched voices.

Persusal of Table II shows that nervousness is the most commonly found symptom in all decades, with irritability second in frequency. The various other symptoms are found to vary in frequency in the various decades; no explanation is offered for this.

TABLE II

	All Cases	Up to and Including 20	21 to 30	31 to 40	41 to 50	Over 50
Nervousness	84.0%	75.0%	80.4%	90.2%	81.2%	100%
Irritability	66.4%	50.0%	57.8%	80.4%	75.0%	50.0%
Melancholy	38.4%	25.0%	39.1%	36.5%	50.0%	58.3%
Crying	37.6%	50.0%	32.5%	53.6%	25.0%	8.3%
Fatigability	38.4%	37.5%	41.3%	41.4%	37.5%	25.0%
"Butterflies"	36.8%	25.0%	39.1%	41.4%	37.5%	25.0%
Cerv. myalgia	28.8%	0	15.2%	39.0%	43.7%	41.6%
Sallowness	16.8%	0	15.2%	17.0%	37.5%	8.3%
Hot flashes	28.0%	12.5%	23.9%	19.5%	50.0%	58.3%
Numbness	10.4%	12.5%	10.8%	4.8%	12.5%	25.0%

Method of Study

The women reported here are those who responded satisfactorily to the administration of estrogens. It is obvious, with this type of approach, that there were frequent errors in diagnosis at first. With the acquisition of more experience in detecting mild degrees of ovarian deficiency, there were fewer cases incorrectly diagnosed as deficiency states.

The results were classified under two heads, "improved" and "controlled." In the first category were those who were given estrogen for a long enough period to be freed from their original complaints and then were able to discontinue medication for six months or longer. Under the "controlled" category were grouped those women who felt well while taking estrogens, but rapidly reverted to their former difficulties on discontinuing the medication.

As a check on statistics, a number of women obviously in the menopause were also included. The response in this group was usually "controlled."

We might consider the "improved" group as those in which the diagnosis of hypo-ovarianism is presumptively correct; the "controlled" group as those in which the diagnosis is definitely confirmed (Table I).

The symptoms noted in these studies included nervousness, irritability, melancholy, crying, fatigability, the nervous epigastric fluttering sensation (termed, for lack of space and a better word, "butterflies"), cervical myalgia, sallowness of skin, hot flashes and numbness of the extremities. The occurrence of these symptoms is reported in Table II, both in total incidence and in incidence in the various decades.

Sallowness, mentioned as a hitherto unreported sign of hypo-ovarianism, does not occur very frequently, being noticed in 16.8 per cent of all cases. It is a difficult sign to recognize in many cases because it is hard to say what a woman's complexion should be until one sees what it can be. Nevertheless, when sallowness is obvious, it is strongly suggestive of an ovarian deficiency.

Complaints.—It was most interesting to observe what was the original complaint which brought the patient in for medical attention. The most common was obesity; this was noted in twenty-seven cases as chief complaint and found in nine other cases besides. Other entrance complaints were as follows: menorrhagia, dysmenorrhea, generalized aching, dizziness, bloating, precordial pain, backache, hot flashes, palpitation, headache, nervousness, anorexia, insomnia, exhaustion, hirsutism, amenorrhea, acne, sterility and pruritus vulvae.

It must be remembered that in addition to these various chief complaints, the patients also had enough of the cardinal complaints to justify a suspicion of hypo-ovarianism, which suspicion was later proved by satisfactory response to administration of estrogens.

Menstrual cycle.—The menstrual patterns of ninety-five patients are represented graphically in Chart 1. If it can be said arbitrarily that the normal menstrual cycle is twenty-eight days and the normal duration of flow is five days, it can be

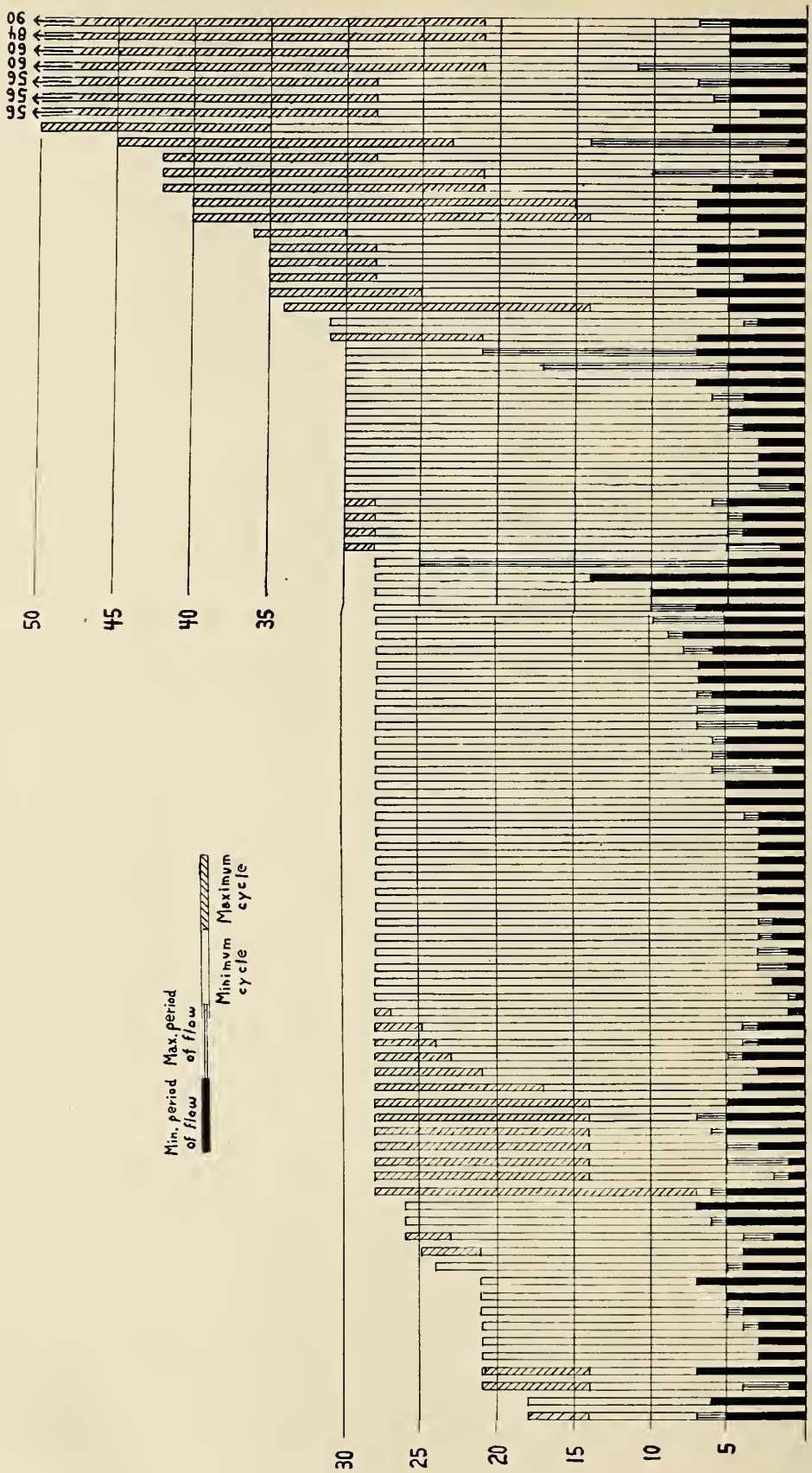
90
84
60
60
56
55
55
50
45
40
35
30
25
20
15
10
5
Min. period of flow
Max. period of flow
Minimum cycle
Maximum cycle

Chart 1.

TABLE III

Age of menarche	10	11	12	13	14	15	16
No. of patients	2	8	13	19	14	8	3
Percentage	2.9%	11.9%	19.5%	28.3%	20.9%	11.9%	4.4%

shown that only two of these women had the normal menstrual pattern.

The successful restoration of menstrual cycle to normal was not studied statistically, due to the fact that these cases were collected before it was decided to analyze them. In general, however, it can be said that in the majority of cases, one can expect to be able to establish a normal menstrual cycle.

Menarche.—It is noteworthy to study the various ages at which the first menstrual period was seen.

As can be seen in Table III, this follows the bell curve of normal distribution. One can therefore say that the average of menarche is thirteen years. It can also be said that only 28.3 per cent of patients menstruate at the normal age or, conversely, 71.7 per cent of this series of patients had abnormal menarches.

Age of patients.—The youngest patient in this series, aged fifteen, had been menstruating since the age of eleven.

Grouped by decades, the distribution of ages was as follows:

Up to and including 20	8
Ages 21 to 30 inclusive	46
Ages 31 to 40 inclusive	41
Ages 41 to 50 inclusive	16
Over 50	12

The oldest patient, aged sixty, had had a surgical menopause (apparently bilateral oophorectomy) at age thirty-five. She had been told that she had had coronary occlusion, in spite of the fact that repeated electrocardiograms had not showed the characteristic tracing. Other symptoms included nervousness, extreme fatigability and cervical myalgia. After administration of estrogen she was completely relieved of the angina pectoris which was thought to be due to coronary disease. She also had a normal menstrual period—the first vaginal bleeding in twenty-five years.

Miscellaneous.—Several other interesting observations were made, impossible of being studied statistically. One was that there is apparently a critical level of estrogen dosage necessary to abolish each separate symptom, and that this varies in different women. For example, consider a woman who complains of hot flashes, crying and nervousness. With a small dose of estrogen it is possible to free her of her flashes; it may take a larger dose of estrogen to abolish her crying and a still larger dose to make her admit she is no longer nervous. This order of disappearance of symptoms is individual for each woman. Certain symptoms are apparently more refractory to treatment than others. A woman with hypo-ovarianism who complains of loss of libido will usually need to take estrogen for a longer period before getting relief than one who does not have this particular complaint. The symptom easiest to abolish in most cases was that of hot flashes. It is now felt that this symptom is not a good criterion of effectiveness of treatment, and that administration of estrogen should be continued until the patient has no complaints or is showing signs of overdosage.

Another observation is the manner in which obese hypo-ovarian patients lose both weight and bulk. It is my practice to try to re-establish a normal estrogen level before recommending diet. Frequently seen is the phenomenon of patients losing 2 inches in waist circumference, 1 inch in trochanteric circumference and, at the same time, *gain* 5 pounds.

When a patient loses weight during administration of estrogens the most noticeable loss will first be in the waist. Later she will lose her trochanteric fat pads.

Medication and Dosage

In this study almost all forms of estrogen were used: stilbestrol, conjugated estrone sulphate and ethinyl estradiol by mouth, aqueous suspension of crystalline estrogens (mostly estrone) and estradiol esters* by hypodermic. The least successful, because of a high incidence of toxic symptoms, was stilbestrol. The most successful, and the one which is now used almost to the exclusion of all others, is ethinyl estradiol (Estinyl*—Schering).

It is felt that the oral administration of estrogens is more apt to be successful than the parenteral route. Most patients have been sold on the idea that estrogens are given only by "shot." When it is pointed out that their ovaries work every day, not once or twice a week, they can better grasp the

*Estinyl and Progynon-B supplied by Dr. W. H. Stoner of Schering Corporation.

reason for a daily oral dosage. This observation is in support of Hamblen's[1] well-expressed views on this subject.

The dosage is the most difficult part of the problem of hypo-ovarianism. There is no standard dose of estrogen which will fit every woman; the patient must be individualized. Some women need, and are benefited by, a dose of 0.02 mg. of ethinyl estradiol per day. Others, to obtain equal relief, need 0.15 mg. or more. The closer the patient is to the menopause, the larger dose she is apt to need. The usual procedure is to start with a dose of 0.05 mg. per day and modify this upward or downward according to the patient's response. The medication is started six days after the onset of a menstrual period and is given for twenty days or until the next menstrual period, whichever time is seen first. Patients are seen about every ten days until the dosage is established, that is, when they obtain maximum relief of symptoms without showing signs of overdosage.

In a series of cases such as this, it is obvious that there were many instances of overdosage. This is often most difficult to determine. In general, we suspect an overdose of estrogen when the patient reports the following: (1) increased soreness of the breasts, (2) a full, bearing-down feeling in the lower abdomen, often described as a feeling of beginning menstruation, (3) a full feeling in the head, most noticeable at the apex.

In the presence of these complaints it is advisable to discontinue the estrogen until after the next menstrual period and then, if one starts the medication again, to give a smaller dose.

It must be remembered that it is possible for a chronic deficiency and an acute oversupply of estrogen to exist at the same time. This can be compared with the person who has been starving, then is given too much to eat. He can have gastric over-distension and malnutrition simultaneously. If the patient persists in an overdose of estrogen she will, of course, develop a profound menorrhagia. An attempt should be made to control this with progesterone and/or testosterone[1] before subjecting the patient to a dilatation and curettage.

Not only must patients be individualized as far as the dose is concerned, but also as to the length of time they need estrogenic therapy. An acute deficiency, such as is seen after hysterectomy or following some severe emotional stress, will usually require estrogens for three months or less. Those unfortunate females who were born with defective ovarian tissue may need to take estrogens indefinitely. It is often a consolation to this sort of patient to point out that, in her case, estrogenic substance is similar to food. It is necessary for continued health and cannot be manufactured by the body. She is not disturbed by the prospect of having to eat every day for the remainder of her life. Why should she be discouraged when she finds it necessary to take a tablet once a day for an indefinite period?

Discussion

This study admittedly does not prove, yet undeniably indicates that there can be such a condition as subclinical hypo-ovarianism. This concept parallels the opinions which grew and changed with our increasing knowledge of vitamins. For example, when we first learned about vitamin B, we believed that a deficiency in this complex gave rise to pellagra or beri-beri. Now we know that there can be mild deficiencies, not severe enough to rise to any clinical entity, but yet enough to prevent a person from enjoying ideally good health. So it is with hypo-ovarianism. A patient may have a deficiency in estrogen production, not enough to give her amenorrhea, genital infantilism or involutional melancholia, but still she can have sufficient disturbance to prevent her from getting the maximum enjoyment from life.

One objection which always crops up in discussing the administration of estrogen is that it depresses the pituitary, and thereby causes a further derangement of endocrine function. This is perhaps true in the individual whose ovarian function is at the optimum level. But judging from the results seen in this group of patients, it is necessary for a woman to have this optimum level of blood estrogen before the pituitary can begin to function properly.

As confirmation of this, we have seen numerous cases of apparent sterility respond to proper doses of estrogen. We have seen early cases of thyrotoxicosis gradually disappear after estrogenic therapy. We have seen cases of habitual abortion apparently cured by administration of estrogen.

Selye[2] has demonstrated quite clearly that many of our so-called degenerative diseases begin first as functional endocrine disorders, as failures of the mechanism of adaptation. Might it not be said that ovarian hypo-function is a predisposing factor in such adaptive failure?

Regardless of these more speculative aspects of the problem, there is one striking effect from administration of estrogen to the patient with hypo-ovarianism. Patients almost unanimously report that it is much easier for them to be happy. Inasmuch, then, as estrogen in properly controlled dosage has never been proved to be harmful, it is believed justifiable to recommend that subclinical hypo-ovarianism be suspected more often and treated accordingly.

Summary

By using the empirical approach, it can be shown that there is an entity which may be called "subclinical hypo-ovarianism."

A typical patient with this condition is one who had her menarche at some other age than twelve or thirteen years, whose menstrual cycle varies from the ideal of every twenty-eight days, and whose duration of flow varies from the ideal of five days; she will have such subjective symptoms as nervousness, irritability or melancholy. Her skin may be sallow. If obese, she has trochanteric fat pads; if underweight, she will have concave buttocks.

Such a patient will be relieved of the majority of her complaints if she receives estrogenic substance in the proper dosage, at the proper interval and for a sufficient length of time.

References

1. Hamblen, E. C.: The female climacteric. Virginia M. Monthly, 67:24, 1940.
2. Selye, H.: The general adaptation syndrome and the disease of adaptation. J. Clin. Endocrinol., 6:117, 1946.

MSMS

FREQUENCY BANDS FOR MEDICAL DIATHERMY EQUIPMENT

Medical diathermy equipment may be operated on the 13.66 megacycle, 27.32 megacycle and 40.98 megacycle bands without license, according to Public Notice No. 7722 of May 9, 1947, released by the Federal Communications Commission. No limit is given to the power output that may be radiated. Diathermy apparatus operated outside the assigned frequency bands above shall be completely shielded and filters placed in the power line. The commission will determine if the diathermy equipment is not operating in compliance with the rules and in such cases will notify the owner, who is responsible for making the changes to prevent interference.

All equipment manufactured before July 1, 1947, will *not* be subject to the new regulation for a period of 5 years (June 15, 1952).

A special band at 2450 megacycles has been made available for industrial, scientific and medical purposes. This is to allow the production of experimental machines of extremely short wave length—approximately 12 cm. long. Such machines have not been used by the medical profession up to the present time. However, this channel may be subject to development in later years as the medical profession either accepts it or not.

Resection of the Head of the Pancreas for Carcinoma

By Alexander W. Blain, M.D., M.S., F.A.C.S.
and Nelson Jarrin, M.D.
Detroit, Michigan

A. W. Blain

THE FIRST operation for carcinoma of the duodeno-pancreatic region was performer in 1898 by Halsted[10] at the Johns Hopkins Hospital. His patient, who had a greatly dilated common duct, associated with a growth at the ampulla, underwent resection of a V-shaped section of the duodenum, including the growth and the first portions of the common and pancreatic ducts. The duodenum was closed and the stumps of both ducts were implanted into the suture line of closure. The patient lived free of symptoms for seven months and then died with a recurrence of the original growth.

At the turn of the century the malignant tumors of this region were considered practically inaccessible by surgeons generally. In 1905, Monynihan,[13] in discussing operations for malignant diseases of the pancreas, wrote: "I have elsewhere collected the records of all cases operated upon—thirteen in number. They all serve to show that the mechanical difficulties of the operation are well-nigh insuperable, and that if boldness and good fortune are the operator's gifts, the result to the patient hardly justifies the means."

According to Allen Whipple,[18] there was no attempt at pancreaticoduodenectomy for cancer involving the pancreas prior to 1935 for the following reasons:

1. The duodenum was believed to be an essential part of the digestive tract.

2. The external secretion of the pancreas was believed to be indispensable for digestion of proteins and fats.

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3. The significance of the fact that pancreatic juice ceases to flow, and that acinar atrophy results with prolonged blockage of the ampulla and head of the pancreas with carcinoma, was not properly understood or evaluated.

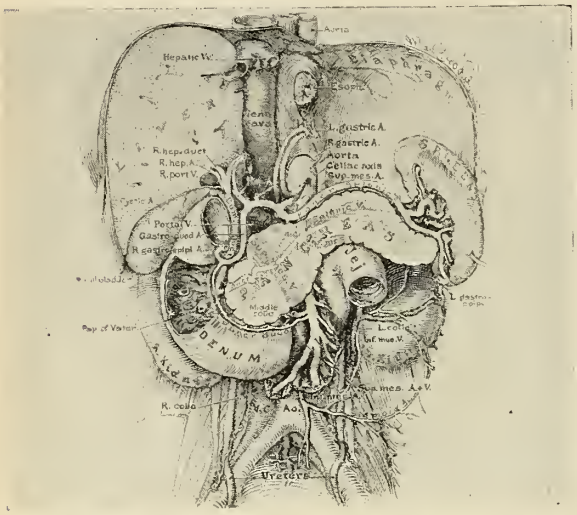

Fig. 1. Normal topography of the upper abdomen. (From a drawing by Max Broedel, published by Trimble et al. Courtesy of *Surgery, Gynecology and Obstetrics.)*

4. For these reasons, even with resections of part of the duodenum, every effort was made to re-establish the flow of bile and pancreatic juice into the duodenum or jejunum.

New hope was afforded patients suffering from carcinoma of the pancreas when Whipple undertook, in 1935, his radical operation for carcinoma of the ampulla of Vater. His great contribution to modern surgery was based on the following considerations: He knew (1) that Coffey,[5] in 1929, and others had demonstrated that the dog could survive total duodenectomy, (2) that patients with ampullary or pancreatic cancer were able to survive months deprived of both biliary and pancreatic contents into the gastrointestinal tract, and showed an atrophy of disuse of the acinar tissue of the pancreas. He believed that if bile could be restored by a short-circuiting procedure, the bleeding tendency would be corrected and digestion of fat improved. At the same operation a gastroenterostomy would prepare the patient for a second stage, at which time radical removal of the duodenum and head of the pancreas, wide of the growth, would be undertaken (Fig. 2).

In March, 1940, Whipple[17] performed the first successful radical one-stage pancreaticoduodenectomy, removing the distal third of the stomach, the entire duodenum, and the head of the pancreas with an antecolic gastrojejunostomy and a choledochojejunostomy.

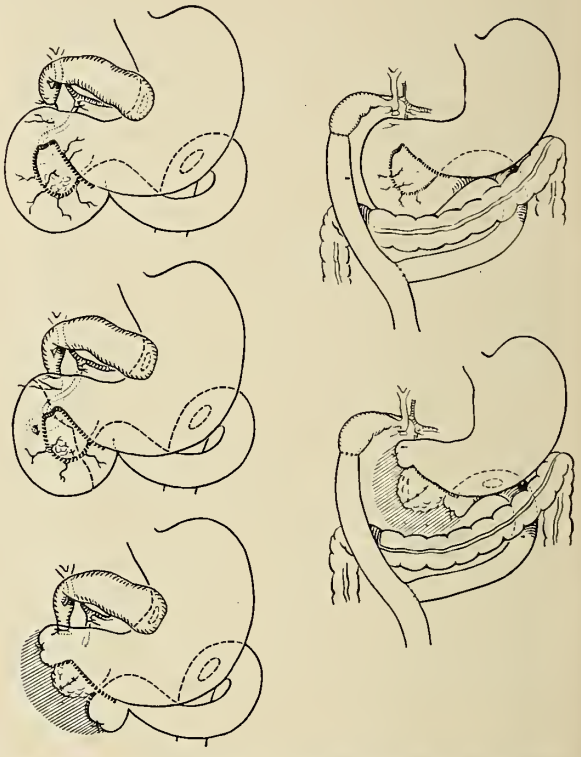

Fig. 2 (*right*) Operation of Whipple, Parsons and Mullins, 1935, and (*left*) operation of Whipple, 1938.

April 26, 1940, I. Ridgeway Trimble[15] performed his one-stage pancreaticoduodenectomy for carcinoma of the head of the pancreas for the first time (Figs. 1, 3 and 4). Alexander Brunschwig[3] has also developed a one-stage pancreaticoduodenectomy. Although first performed in 1939, his first successful case was operated upon in 1942. Brunschwig has summarized his technique as follows: "Continuous spinal anesthesia is used, if possible, and silk technique is followed throughout. The chief steps in the operation are:

1. A high midline, transverse, or inverted T-incision.

2. The head of the pancreas and duodenum are mobilized by incision of the peritoneum along the greater curvature of the duodenum. This step aids in ascertaining if the neoplasm has invaded the first portions of the portal vein.

3. The lower stomach is transected and the upper segment is closed. The superior pancreatoduodenal artery is divided near the duodenal wall.

4. The common bile duct is transected at or slightly below the level of the upper margin of the first portion of the duodenum.

5. The neck or proximal portion of the body of the pancreas is transected at the level of, or slightly to the right of the superior mesenteric vessels. In the stump of the pancreas, the main pancreatic duct is secured in a hemostat twisted through a 90 degree arc, and ligated. The pancreatic parenchyma is sewed by interrupted interlocking mattress sutures that are not tied too tightly.

6. The superior mesenteric vessels are elevated from the uncinate process of the pancreas and the third portion of the duodenum.

7. The ligament of Treitz is incised, thus freeing the duodenojejunal junction and facilitating transection of the jejunum distally.

8. The jejunum, 3 to 6 centimeters distal to the ligament of Treitz, is transected, and the lower segment is closed by three concentric purse-string sutures (linen). Duodenum, head of the pancreas and lower segment of common bile duct are removed.

9. Posterior gastrojejunostomy is done.

10. The transverse mesocolon is incised to permit the first long loop of the jejunum to be brought upward for the choledochojejunostomy. The latter may be done "anteriorly."

11. A jejunojejunostomy is made below the opening in the transverse mesocolon between efferent and afferent loops of jejunum going to the choledochojejunostomy.

12. A soft rubber drain is applied to the site of the head of the pancreas and the abdominal wound is closed.

Only twelve cases of radical resection of the head of the pancreas had been reported up to 1940, of which six survived operation (Crile). Crile[6] added a thirteenth case from the Cleveland Clinic.

Cattell[4] in reporting eighteen cases of malignancy of the pancreaticoduodenal region at the Lahey Clinic subjected to radical operations up to 1945 stated that up to 1945 "approximately 100 operations that could be termed radical in the usual sense applied to the surgical treatment of malignant tumors had been performed for tumors of pancreaticoduodenal region." He reported satisfactory results in thirteen of the eighteen cases.

In February, 1946, Waugh and Clagett[16] were able to report before the Central Surgical Association a series of thirty cases in which resection of the head of the pancreas and duodenum was performed for carcinoma in this region with an operative mortality of 20 per cent. The postoperative survival on a short follow-up in these cases was disappointing in the seventeen cases in which operation was done for carcinoma of the head of the pancreas, but was encouraging in those in which it was done for carcinoma of the ampulla of Vater.

The case to be reported in this communication represents the first successful one-stage pancreatoduodenectomy for carcinoma of the head of the pancreas to be performed at the Alexander Blain Hospital.

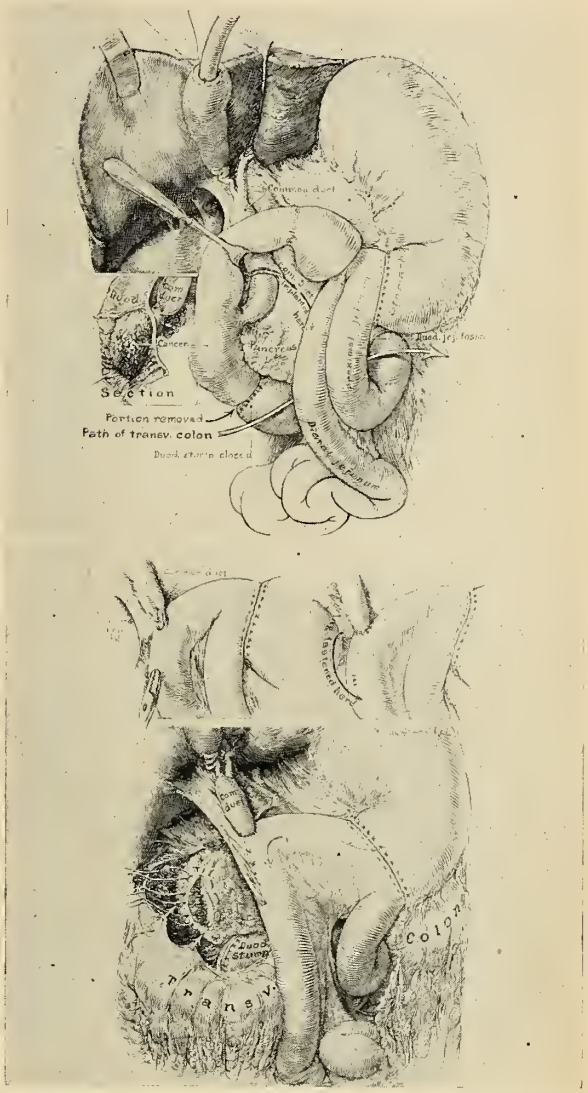

Fig. 3. Operation of Trimble, Parsons and Sherman shows resection of the duodenem, pyloric end of the stomach, common duct, and head of the pancreas. Also shown is the anterior Polya anastamosis employed, the transverse colon being omitted from the drawing for the sake of clearness. (Courtesy, *Surgery, Gynecology and Obstetrics*).

Fig. 4. Operation of Trimble, Parsons and Sherman shows suture of the pancreatic stump, including the pancreatic ducts and the implantation of the stump of the common duct into the jejunum. (Courtesy, *Surgery, Gynecology and Obstetrics*).

Case Report

A.B.H., hospital number, F-5249, a white woman, sixty-three years of age, was admitted to the hospital on November 6, 1946, with a chief complaint of pain in the upper abdomen of two weeks' duration, boring pain in the

back, loss of weight, weakness and loss of appetite. The patient had noted a loss of weight for the past six months, during which time she had been eating poorly. The few times that she forced herself to eat, she felt a fullness and

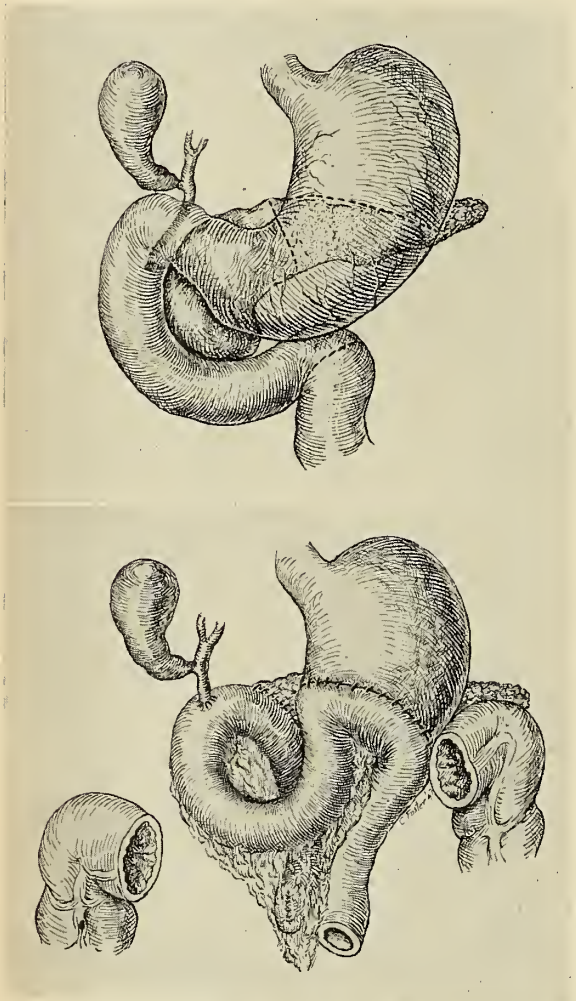

Fig. 5. The line of resection of the stomach (transverse dotted line) and line of resection of the pancreatic head (vertical dotted line) are shown. Below is the site of resection of the duodenum just beyond the ligament of Treitz (transverse dotted line).

Fig. 6. Suture of the pancreatic stump to the jejunum; the choledochojejunostomy, and the end-to-side isoperistaltic gastrojejunostomy.

discomfort of the stomach, followed by nausea without vomiting. During the last few days, the stools had been light yellow in color and fetid, and she had noted an increase of the dorsal pain. Her weakness had increased rapidly.

Physical examination revealed a pale, poorly nourished woman, showing marked emaciation. Temperature was 101°; pulse, 76; respirations, 22; systolic pressure, 190; and diastolic pressure, 110. The heart was enlarged, with a double first sound at the base; no murmurs were heard. The abdomen showed a suprapubic postoperative scar, well healed. The abdominal wall was relaxed. A mass was palpated in the right upper quadrant, which was egg-size, smooth, not tender on palpation and which seemed to be attached to the liver. In the epigastrium another mass was felt, smaller in size, nodular and immovable and also not tender on palpation. The extremities showed evidence of hypertrophic arthritis of both knees with muscular atrophy.

Urinalysis revealed a specific gravity of 1.022; acid reaction; sugar and albumin, negative; occasional white blood cells and occasional renal epithelial cells. Complete blood count was as follows: hemoglobin, 11 gm. or 71 per cent; red blood cells, 3,670,000; white blood cells, 3,400. Differential count showed non-filamented neutrophils, 23; filamented neutrophils, 32; lymphocytes, 41 and monocytes, 4.

A flat plate of the abdomen was of no diagnostic aid. Cholecystograms revealed a nonfunctioning gall bladder. The gastrointestinal series showed the stomach to be pushed over towards the left, "evidently by an abdominal mass in the right upper quadrant." The stomach outlined well and showed no organic defects. The bulb filled and showed no constant ulcer deformity. An hour film showed no gastric obstruction. Fluoroscopic examination of the esophagus showed no obstruction. Kidney-ureter-bladder films and intravenous pyelography were negative for significant findings.

Because of the marked emaciation and weakness associated with an epigastric mass and what was believed to be a distended gall bladder, plus the presence of epigastric pain and boring back pain, a tentative diagnosis of neoplasm of the pancreaticoduodenal area was made. Exploratory laparotomy was performed on November 13, 1946, after the patient's condition had been improved somewhat by preoperative feedings. Under nitrous oxide and oxygen anesthesia and local infiltration with procaine, an upper right rectus transverse incision was made, dividing the right rectus muscle. The gall bladder was found to be enlarged to about three times its normal size and the cystic and common ducts were dilated. The liver was of normal size and consistency. At the head of the pancreas there was a hard, nodular mass, the size of an egg, which was fixed to the duodenum. The body and tail of the pancreas were normal, and there were no metastatic lymph nodes present. A diagnosis of carcinoma of the head of the pancreas was established and gastropancreaticoduodenectomy was decided upon. The original incision was enlarged transversely to the left, dividing the left rectus muscle in its upper third. After dissection of the distal third of the stomach by means of division and ligation of the vessels in the distal third of the lesser and greater curvatures, the stomach was divided at the junction of the lower third. The duodenum was mobilized by incising the peritoneum in the periphery. The common duct was exposed and the lower portion of the stomach was rotated to the right, in this way exposing the right gastric artery and the gastroduodenal artery. After the gastrohepatic ligament was opened, the arteries were then divided and ligated. The body of the pancreas was dissected from the posterior attachment and a clamp was placed grasping the gland 1 inch from the head of the pancreas. The gland was divided, the bleeders were controlled and the freed portion of the pancreas was elevated to the right. The superior mesenteric ves-

sels were exposed and the uncinate process was freed from the superior mesenteric vein where it was attached. The remaining vascular attachments to the head of the pancreas and the duodenum were clamped and divided and

Fig. 7. Diagrammatic sketch of the tumor and illustration of the gross specimen removed, after fixation. The body and tail were not removed.

then ligated. The angle of Treitz was exposed, clamped and divided. The common duct was clamped and divided at the level of the lower third. The lower third of the stomach, the duodenum, the head of the pancreas, together with 1 inch of the body and the lower third of the common duct, were removed en masse (Fig. 5). The bowel was closed with two layers of interrupted silk and the digestive tract was reconstructed by bringing a loop of the jejunum retrocolically and anastomosing proximally the remaining pancreas with the jejunum, end to side, using three layers of interrupted silk sutures. About 10 centimeters from this anastomosis, the common duct was attached to the jejunum, end to side, using two layers of black silk sutures, interrupted. Ten inches lower from this site the gastrointestinal tract was re-established by means of an end-to-side antiperistaltic gastrojejunostomy as shown in Figure 6. The opening of the transverse mesocolon was closed loosely, leaving free passage to the jejunal loop used in the anastomosis and the abdomen was closed in layers, after inserting a Penrose drain at the level of the anastomosis and placing 5 gm. of sulfanilamide in the upper peritoneal cavity. A total of 1,000 c.c. of whole blood was given during the operation.[2]

Microscopic examination of the specimen removed (Fig. 7) revealed the larger portion of the tissue to be made up of a thick, firm mat which had destroyed almost all of the pancreas. There were a few islets of normal looking pancreatic tissue which remained. These were encircled by dense connective tissue. In the stroma there were a large number of quite large glands which appeared to be invading the surrounding structures (Fig. 8). Diagnosis: chronic, severe, interstitial pancreatitis with adenocarcinoma of the head of the pancreas.

The patient made an uneventful recovery following the operation and was ambulated early (she was up

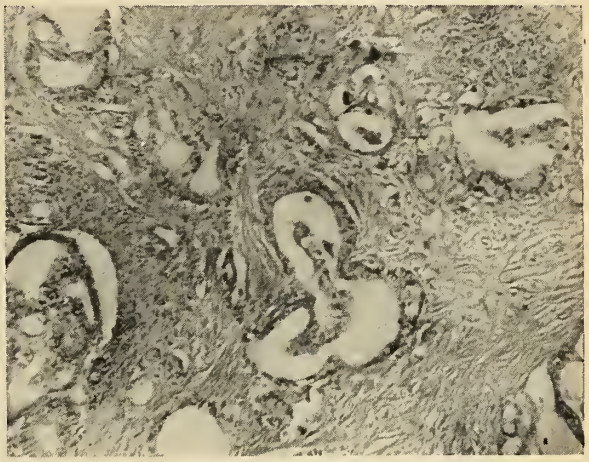

Fig. 8. Photomicrograph of tumor. This was an adenocarcinoma, and the disorderly growth and invasion of glandular epithelium may be seen. There was also severe chronic pancreatitis.

and walking on the second postoperative day). The Penrose drain was removed on the fifth postoperative day. The wound healed by primary intention, and the patient was discharged from the hospital on the thirtieth postoperative day, in good condition.

On postoperative checkup, the blood sugar was 100 mg. per cent; there was a moderate amount of fat in the stools, and the icterus index was 6.2 units.

On February 28, 1947, the patient was readmitted to the hospital because of malnourishment. She had not been eating the diet prescribed for her but had been having only a bowl of soup daily since she left the hospital. Laboratory examinations at that time showed the icterus index to be 6.2 units; blood sugar, 107 mg. per cent. The feces were negative for bile, positive for urobilinogen and positive for fat. Blood count showed red blood cells, 3,820,000; white blood cells, 5,900; hemoglobin, 11.5 gm. and color index, 0.99. A low fat diet was utilized, and she rapidly gained weight.

The patient had progressed so satisfactorily that she was discharged from the hospital on March 25, 1947. The use of large quantities of oral pancreatic extract has not been deemed necessary thus far in her case. At this writing, the patient is well and without evidence of any recurrence of her carcinoma, some eleven months postoperatively. She has been slow, however, in gaining weight.

Discussion

Although this report deals mainly with the surgical technique of resecting carcinoma of the head of the pancreas, a few words concerning the diagnosis of this lesion seem indicated. The operation can only be performed in those cases in which

the diagnosis has been established early enough to allow complete excision.

The classical onset of gradually deepening, painless jaundice often indicates that the lesion has already progressed to a point at which radical excision is impossible. The decision, as to resectability, however, can only be made in such cases at laparatomy.

Courvoiser's Law, although currently held in disrepute in some quarters, may still be a valuable diagnostic aid, as Lahey[12] and others have pointed out. This law states: "In the presence of jaundice a distended gall bladder which is palpable through the abdominal wall is indicative that the obstructive jaundice is due to carcinoma of the head of the pancreas, or to carcinoma of the common duct below the point where the cystic duct enters the common duct. In the presence of jaundice, a contracted gallbladder is indicative that the biliary obstruction is due to stones within the common duct." Although we admit that there is a considerable percentage of error associated with Courvoiser's Law, we believe it is of value. Irvin Abell, Jr.[1] found that in twenty-two cases of painless jaundice, if Courvoiser's Law is modified to mean the distended gall bladder as seen at laparotomy rather than as palpated preoperatively through the abdominal wall, the attendant inaccuracies would be further diminished. In our case, as previously stated, the gall bladder was distended both to external physical examination and to direct inspection at operation. A distended gall bladder has been found in four-fifths of the cases studied at operation and at autopsy by Ingelfinger.[11]

But what of the diagnosis prior to the onset of jaundice? It is here that diagnostic acumen must be developed if the mortality associated with cancer of the pancreas is to be reduced. As long ago as 1919, Thomas B. Futcher[9] of Johns Hopkins stressed in this country the importance of pain as an early symptom which in certain cases may furnish a valuable diagnostic clue. Friedenwald and Cullen,[8] as well as others, further stressed this point. Pain may be of three general types (Ransom[14]). It may be a steady, boring ache in the epigastrium, extending into the back, as in our case; it may occur in severe paroxysms, arising in the epigastrium or either hypochondrium, and radiate to the back, flanks or lower abdomen; and the third type of pain is a colicky cramp in the right upper quadrant, appearing at the time of the onset of jaundice and then subsiding. It is common for more than one type of pain to occur in the same patient (Dunphy[7]). Diarrhea is an uncommon symptom. Weight loss and emaciation are, of course, important signs of neoplasm and, when associated with progressive anorexia, fatigue, weakness, pain as described above, jaundice, a palpable epigastric mass or some combination of these findings, may readily suggest carcinoma of the pancreatoduodenal region.

X-rays of the stomach and duodenum should be examined with great care, for while they are not specific for carcinoma of the head of the pancreas, they may lend valuable supportive evidence. Abnormalities of the duodenal loop are sometimes seen.

Among the various laboratory tests that may be of aid when considered with the clinical picture are lack of urobilinogen in the urine associated with acholic stools, high serum lipase and a normal serum amylase, absent or diminished pancreatic enzymes in the pancreatic secretion and stools containing an excess amount of fat and nitrogen. Hyperglycemia, impaired glucose tolerance and elevation of the sedimentation rate may also occur as nonspecific associated findings.

Probably the most important thing for both the surgeon and the general physician to remember is the importance of pain as an early symptom. Further, when there is evidence that carcinoma of the pancreas might be present in a patient, exploratory laparotomy, rather than expectant treatment, must be employed if cures are to be achieved.

Summary

The operative technique employed in pancreaticoduodenectomy for cancer of the head of the pancreas has been discussed, and the first successful one-stage resection of the head of the pancreas for carcinoma at the Alexander Blain Hospital is reported. A brief discussion of some features of the early diagnosis of this disease is presented. When the diagnosis of cancer of the head of the pancreas is made early, preferably before the onset of jaundice, resection of the tumor and surrounding tissues offers a hope of cure.

The best technique at the present time, when possible, would seem to be the one-stage radical pancreaticoduodenectomy, employing, in any given case, appropriate variations of the procedures illustrated.

(References on Page 1183)

A Case of Snapping Thumb

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CHRONIC NONSPECIFIC tenosynovitis or tendovaginitis stenosans when first described was associated only with the tendon sheath of the abductor pollicis longus and the extensor pollicis brevis tendon.[5] However, since that time it has been shown that many other tendons and their sheaths are involved.

The disease is characterized by a localized enlargement of the tendon with or without thickening or stenosing of its sheath. When the flexor pollicis longus is affected, it gives rise to a clinical entity known as a trigger or snapping thumb.

Most authors[4,6,8,12,14] believe the etiology of chronic nonspecific tenosynovitis is trauma, which may be acute but more frequently is chronic in character and is usually found in individuals who use their fingers or wrists a great deal. In carefully done experiments, Finklestein[7] was able to produce similar lesions in rabbits by various types of trauma, and Lipscomb,[13] in reviewing 190 cases (only eleven involving the flexor pollicis longus) seen at the Mayo Clinic, found a definite history of trauma in ninety-two (48 per cent).

While many workers favor trauma as the cause, some believe that tenosynovitis involving the flexor pollicis longus may be of congenital origin. Compere,[2] in reviewing thirty-eight cases and reporting a patient with bilateral involvement, states that in seventeen of the forty cases, nodules were found in the tendon. He states "the slight enlargement of the tendon may have dated from intra-uterine life, while the constant use of the thumbs not only may have contributed to irritation, thickening and narrowing of the tendon sheath, but caused further enlargement of the tendon nodules themselves." Hudson[10] reported eight cases (two bilateral) which were all observed before the age of three years, and all had a localized enlargement of the tendon leading to a disproportion between the tendon and the sheath. In only one was a definite history of trauma obtained and in one a familial history was noted. Jahss[11] reported ten operative cases whose ages ranged from three and one-half months to fifteen years. Seven of his cases were unilateral, and three had bilateral involvement. One patient gave a history of having the condition for a few weeks, one for a few months and the remaining patients, including the fifteen-year-old child, were said to have had this condition since birth. However, Jahss did not believe the etiology was of congenital origin. Hart[8] believes that on rare occasions this condition may be due to a congenital malformation, while others believe that the etiology of this condition is due to a secondary foci of infection,[1] or to unusual muscular exertion.[3,9,15]

Prior to 1931 many opinions prevailed as to the pathologic condition involving the tendon and its sheath. However, at that time, Finklestein[7] in an extensive review showed that the pathological pictures described by other workers were merely various stages of a progressive chronic process. He pointed out that in mild cases the sheath may be slightly thickened with no definite visible inflammatory changes, and in severe cases it is markedly thickened, fibrosed and at times even cartilaginous in appearance. Lipscomb[13] in reviewing fifteen operative cases (two on the tendon sheath of the flexor pollicis longus), came to the same conclusion.

Compere,[2] in describing the microscopic picture, found "numerous cartilage-like cells among the dense fibrous tissue of the tendon." Hudson[10] removed a thickened substance resembling cartilage which microscopically revealed fibrous and fatty tissue, the fibrous tissue resembling scarred tendon. In another case of his, a small fibroma, measuring about 0.5 cm. in diameter, was found in the deep portion of the sheath at the metacarpophalangeal joint. It was adherent to the tendon. The histological picture was consistent with a congenital anomaly and can be best described by the term "cartilaginous transformation of fibrous tissue."

The symptoms of a "snapping thumb" are difficulty and, in some cases, even inability to flex or extend the thumb. Motion is usually accompanied with a typical "snap" or "click" as the tendon attempts to pass under the constricting portion of the sheath. This may or may not be accompanied with pain, but in all cases it is usually of great annoyance to the patient and frequently the affected hand is weaker than the normal hand.

This lesion is found more commonly in females. The age incidence is variable, and although recent reports tend to indicate that it is more commonly

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found in children, Compere's series[2] showed an age range from two years to seventy-one years.

While involved tendons, other than the flexor pollicis longus, may be treated by conservative

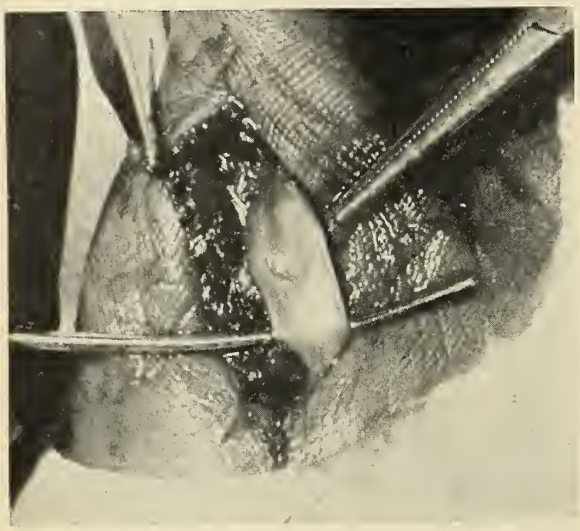

Fig. 1. Nodule on tendon in a case of chronic nonspecific tenosynovitis.

methods (splinting, roentgen therapy, heat, massage, et cetera), the snapping thumb is better treated by surgical means. This consists in incising the sheath and removing part of it. If a nodule is present this may or may not be removed. Recurrences are rare.

Many of the authors reporting on this condition state that it is much more common than generally reported, and that it is often diagnosed incorrectly.[2,6,7,11,13] Because of this fact and because there is a good deal of discussion as to the origin of this condition we are reporting the following case.

Case Report

C. G., an eleven-year-old colored girl was first seen in July, 1943, because of a fractured tibia and fibula. Convalescence was uneventful. However, while she was being observed it was noticed that she had a peculiar jerking motion of her thumb. The patient and her mother stated that as long as either of them could remember there was a definite snapping sensation when the left thumb was either flexed or extended. In addition, this thumb was weaker than the right one. There was no pain, nor was there any history of definite trauma.

The patient's past health had been good and no similar lesions had been noted in other members of the family. Physical examination revealed no abnormalities except a "snapping" left thumb. Here it was noted that when the distal phalanx was flexed or extended on the proximal one there was a definite jerk in the motion. The left thumb was weaker than the opposite thumb, and its opposing action to the rest of the finger was definitely diminished when compared with that of the right thumb. A small palpable nodule was present over the course of the tendon near the metacarpal-phalangeal joint of the left thumb.

A diagnosis of tenosynovitis stenosans was made and the patient was admitted for surgical treatment. An incision about 1½ inches long was made, slightly lateral to the flexor pollicis longus and extending about halfway above and below the metacarpophalangeal joint. The subcutaneous tissues were separated, the tendon sheath was identified and opened. A small nodule about the size of a "BB" shot was removed from the tendon (Fig. 1). The sheath of the tendon was slightly constricted distal to the nodule. Accordingly the sheath was left open. The subcutaneous tissue was approximated and the skin was closed with interrupted vertical mattress fine silk sutures. Following the application of bandages the thumb was splinted in slight flexion.

Microscopically the nodule showed a localized area in which excessive irregular collagen, mild interstitial edema, and occasional lymphocytes and plasma cells were present. Nothing that could be interpreted as related to embroyonal tissue could be seen. The pathologic diagnosis was nonspecific tenosynovitis of moderate severity.

Healing occurred by primary intention and five days later when the sutures were removed, gentle motion was started. An excellent result was obtained and follow-up one year later revealed no recurrence. The mother and child state that the thumb has gradually increased in strength and now is equal to that of the right hand.

Discussion

As has been pointed out, there are two opposing views as to etiology in these cases. The congenital factor is strongly supported by the age incidence of many cases and the history of the condition having been present since early life. Our case falls into this group. However, the pathologic changes found in surgical material can be reproduced by trauma. Further there is nothing in the pathologic picture of this case that could be construed as being residual embryonic tissue. It is well known that minor traumatic episodes can be easily forgotten and the inability to elicit such data does not rule out the possibility of its having occurred. From the evidence at hand in this case, no positive statement of the etiology of snapping thumb is possible at present.

Conclusion

An additional case of chronic nonspecific tenosynovitis involving the flexor pollicis longus tendon in an eleven-year-old negress is presented.

References

1. Cohn, A.: Occupational thecitis. New York State M. J., 104:685-686, 1916.
2. Compere, E. L.: Bilateral snapping thumbs. Ann. Surg., 97:773-777, 1933.
3. Conn, H. D.: Tenosynovitis. Ohio State M. J., 27:713-716, 1931.
4. Cotton, F. J.: Trigger Finger. Am. J. Orthop. Surg., 8:587, 1910-11.
5. De Quervain, F.: Über eine Form von chronischer Tenddovoginitis Cor.-Bl. f. Schweiz. Aerzte, 25:389-394, 1895.
6. Diack, A. W., and Trommald, J. P.: De Quervain's disease, a frequently missed diagnosis. West. J. Surg., 47:629-633, 1939.
7. Finkelstein, H.: Stenosing tendovaginitis at the radial styloid process. J. Bone & Joint Surg., 28:509-540, 1930.
8. Hart, D.: Practice of Surgery, Lewis-Walters, 5:230, 1944.
9. Howard, N. J.: Peritendinitis crepitans, a muscle effort syndrome. J. Bone & Joint Surg., 19:447-459, 1937.
10. Hudson, H. W.: Snapping thumb in childhood. New England J. Med., 210:854-858, 1934.
11. Jahss, S. A.: Trigger finger in children. J.A.M.A., 107:1463-4, 1936.
12. Keen, W. W.: Keen's Surgery. Philadelphia: Saunders, 1906.
13. Lipscomb, P. R.: Chronic Nonspecific Tenosynovitis and Peritendinitis. S. Clin. North America, 780-797, 1944.
14. Zelle, O. L., and Schnepp, K. H.: Snapping thumb: tendovaginitis stenosans. Am. J. Surg., 33: 321-322, 1936.
15. Zollinger, F.: Tendovaginitis and bursitis. Arch. F. Orthop., 24:436-467, 1927.

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AMERICAN ACADEMY OF ALLERGY

The American Academy of Allergy will hold its annual convention at Hotel Jefferson, St. Louis, Missouri, December 15-17, inclusive. All physicians interested in allergic problems are cordially invited to attend the sessions as guests of the Academy by registering without payment of fee. The program, the scientific and technical exhibits have been arranged to cover a wide variety of conditions where allergic factors may be important. Papers will be presented dealing with the latest methods of diagnosis and treatment as well as the results of investigation and research. Round table conferences will be held on Monday afternoon, December 15, 1947. Advance copies of the program may be obtained by writing to the Chairman on Arrangements, Charles H. Eyermann, M.D., 634 North Grand Boulevard, St. Louis, Missouri.

RESECTION OF THE HEAD OF THE PANCREAS FOR CARCINOMA

(Continued from Page 1180)

References

1. Abell, I., Jr.: Internat. Clin., 4 (series 3):225-228, 1940.
2. Blain, A. W., and Jarrin, N.: Alexander Blain Hosp. Bull., 4:15-17, 1945.
3. Brunschwig, A.: Surg., Gynec. and Obst., 77:581-584, 1943.
4. Cattell, R. B.: New England J. Med., 232:521-526, 1945.
5. Coffey, R. C.: Ann. Surg., 50:1238, 1909.
6. Crile, G., Jr.: Am. J. Surg., 67:87-95, 1940.
7. Dunphy, J. E.: Am. J. Digest. Dis., 7:69-70, 1940.
8. Friedenwald, J., and Cullen, T. S.: Am. J. M. Sc., 176:31, 1928.
9. Futcher, T. B.: Tr. A. Am. Physicians, 34:284, 1919.
10. Halsted, W. S.: Bull. Johns Hopkins Hosp., 11:1-11, 1901.
11. Inglefinger, F. J.: New England J. Med., 235:653-660, 1946.
12. Lahey, F. H.: S. Clin. North America, 17:753-762, 1947.
13. Monynihan, B. G. A.: Abdominal Operations. Philadelphia and London: W. B. Saunders, 1905.
14. Ransom, H. K.: Am. J. Surg., 40:264-281, 1938.
15. Trimble, I. R., Parsons, J. W., and Sherman, C. P.: Surg., Gynec. and Obst., 73:711-722, 1941.
16. Waugh, J. M., and Clagett, O. T.: Surgery, 20:224-232, 1946.
17. Whipple, A. O.: Ann. Surg., 114:612, 1941.
18. Whipple, A. O.; Parsons, W. B., and Mullins, C. R.: Ann. Surg., 102:763, 1935.

Psychiatry and Psychosomatic Medicine Viewed by an Internist

By Bruce C. Lockwood, M. D.
Detroit, Michigan

THE PSYCHONEUROTIC problem is with us and in immense proportions. The problem is too great for the psychiatrists alone to handle. More help is needed from the rest of medicine especially from the specialty of internal medicine, where the knowledge of physiology, biochemistry and clinical medicine should be of value.

This fact is admitted by the psychiatrists who berate the ordinary physician for his lack of knowledge and lack of interest in psychosomatic and other behavior disorders.[5] It is without doubt true that many general physicians do not like to give medical attention of these unhappy, frustrated and often aggravating patients. On the other hand, many physicians, more adept in the "art of medicine" find that their own brand of psychotherapy has been meeting with a reasonable degree of success, and therefore see no great value in the work of the psychiatrist except in the care of the frankly psychotic patient.

In the past there has been somewhat of a chasm between psychiatry and the rest of medicine. Perhaps it has not been nearly as wide as it has seemed to be. Psychiatrists are physicians who have made a special study of normal and abnormal psychology. It is natural that they at times should be rather intolerant and critical of the indifference and ignorance shown by their brother physicians regarding the nomenclature and methods of their new Dynamic Psychiatry.

On the other hand, it seems that most physicians have not had sufficient confidence or trust in psychiatry. This I believe is because the subject has been badly presented by the psychiatrist. As an internist forced to take an interest in the subject, I feel that this misunderstanding is partly because we have not tried to learn and partly because of other reasons now to be discussed.

From the Department of Internal Medicine, Harper Hospital, Detroit, Michigan.

First, it is fair, I think, to expect authorities on a subject to be able to present their subject in a manner intelligible to other thinking people. This has been well done in the complex fields of chemistry, physics, and biology. Modern dynamic psychiatry, however, got off to a bad start in adopting a nomenclature, definition, and method of reasoning foreign to previous scientific thinking.

Not all psychiatrists, however, have been in sympathy with the "psychiatric approach" of modern psychiatry to the rest of medicine. I quote Burlingame,[6] who says, "Conservative members of the profession were nearly engulfed in a sea of complexes, fixations, transferences, and cross transferences, and they swam hopelessly against being engulfed in a veritable deluge of metaphysical and highly theoretical hypothesis." Even the psychiatrists could not understand each other.

Second, the subject of sex has been poorly presented because of the manner of terminology and of emphasis. The importance of sexuality in adolescent and adult life, when the sex hormones are active, in determining behavior is recognized. Pregenital infantile sexuality, however, has not and cannot be recognized as a determining factor in adult behavior. The Oedipus complex, the story of the young male who killed his father because of his love of his mother, does not conform to practical findings; the same is true of Electra who so loved her father. Most physicians cannot link a sex connection with the method of early bathroom training.

From a medical diagnostic standpoint the "psychiatric approach" by the psychiatrist to the rest of the medical profesion has been poor. There has been a lack of "rapport" on the part of psychiatry. For this reason the more general use of good psychotherapy has been retarded. This has contributed to the success of the suggestive therapy methods used by charlitans and certain religious cults.

Another difference of opinion between the psychiatrist and the rest of the medical profession has had to do with the influence of hereditary constitutional factors on behavior reactions. Medical men do not believe that early environment is the only factor in causing peculiar behavior. This will be further discussed later.

Another criticism directed against many psychiatrists is that they are inclined to forget or ignore their early scientific medical training, and become lost in a maize of psychiatric suppositions. Many in the past have used suggestion too much as a form of therapy, even in cases of organic disease, rather than using sound medical methods of diagnosis and therapy.

Medical men, further, cannot agree that the physician himself should have some behavior disorder in order to best advise the psychoneurotic. Yet a prominent psychiatrist[12] recently wrote, "It would be well if the psychiatrist has had (or may still have, not impossible) some difficulty of his own that may have adequately sensitized him to the suffering of others so that he may be personally aware of what he may have to help another person face. It is very likely that a man without his own personal difficulty would never have been drawn to psychiatry."

Further quoting the same writer regarding psychotherapeutic ability, it is stated that the psychotherapeutist should have, "The self-confidence of a free manhood which is not to be gained by any intellectual means, but solely by selfproving with the complete co-operation of the personality."

I agree with Palmer[13] that psychiatry and psychotherapy is pretty much an attempt to analyze and better understand the "art of medicine," convert it into a science, and perhaps measure it.

There is now, fortunately, rapidly approaching, the realization by the whole medical profession that psychiatry is not esoteric and that the "uninitiated" as well as the "initiated" should, must, and can labor in the same vineyard.[2]

Psychoneurotic, psychosomatic and mental disorders are not a new thing. They are very old conditions that more recently have been dressed up with new names and descriptions and explanations. The skulls of prehistoric men have frequently shown trephine holes, probably done during life to let out devils and cure mental diseases.

It seems probable, however, that in recent times there has been an increase in behavior disorders. The writer feels that a great contributing environmental factor has been the helplessness, insecurity, loss of liberty, and depression in which many have found themselves in the wave of modern social trends, with associated wars-to-prevent-wars and political, economic and social uncertainties.

The nervous system tissue is made up of cells developed in the process of evolution to expedite conduction of stimuli from one part of the body to another. Man's large amount of nerve tissue, including the spinal cord and brain, provides the

basis for his variable reaction to environment and his variable behavior, as well as for his memory, education and reason.[8,14,15,17]

Etiology of Abnormal Behavior

Behavior, normal and abnormal, is usually dependent upon more than one of the following factors: heredity, organic nervous system changes, and emotional disorders.

Heredity.—It cannot be disputed that all individual structural differences in living organisms, plant or animal, including man, are determined by heredity. These individual variations occur in the nervous system tissue as well as in the other structures more apparent to the eye. They are dependent upon the individual peculiar type and arrangement of the chromosomes and genes, derived from the parent sex cells. The laws of heredity have been established by study and experiment since Mendel first described the genes in the middle of the last century. Thus it seems probable that heredity is the chief determining factor in the following traits: physical structure, intelligence, energy, temperment, and the sumation of these things which is called the ego, or personality.

There are without doubt many inherited structural differences in the nervous system as well as in other parts of the body. These differences influence intelligence, energy, temperment and emotional stability. The variation is great in different human individuals and families as well as in different families of animals.

Only persons with constitutional hyper-irritable sensitive nervous systems can be influenced by environmental factors to develop psychoneuroses.[4] However, since nothing can be done to improve the heredity of a patient, everything possible should be done to improve his environment and learned behavior. This argument has been given by psychiatrists for their statements that heredity plays only a very small part in the psychoneuroses. They say that it is a more optimistic viewpoint.

Organic nervous system changes and chemical reactions are another major cause of behavior disorders. The following conditions should be considered in every instance of nervousness: (1) Nutritional disorders—Vitamin B deficiencies. Pellagra. Anemia. Low blood sugar. Low blood chlorides. (2) Endocrine disorders. Menopause. Thyroid disease. (3) Drug toxemia. Ether, alcohol, barbiturates, opiates, et cetera. (4) Infection toxemia. Pneumonia, typhoid, et cetera. (5) Brain inflammation—Encephalitis. General Paresis. Meningitis. (6) Brain injuries. Brain tumor. (7) Brain circulatory changes (anoxia), as seen in heart disease, cerebral sclerosis and cerebral hemorrhage.[3]

Psychogenic or Emotional Disorders.—There can be no question but that abnormal emotional reactions are very frequently the cause of abnormal behavior in both the voluntary and the involuntary system.

A short review of psychology and of fundamental behavior characteristics is in order: There are *inherited unlearned nervous behavior reactions* such as the *reflexes, instincts,* and normal *emotions,* which are common to all families and species, the same as there are *inherited physical characteristics.* Both are subject to the individual variation, such as, for example, the lazy work horse compared with the nervous racehorse, or the greyhound compared with the pointer, both differ in physical structure and temperment due to inherited characteristics. There are even minor differences in families, such as the ability of running horses to race well on a dry or wet track, the Sea Biscuit and Man of War progeny as compared with the Whirlaway and Gallant Fox progeny.

These inherited characteristics are said to be *conditioned* when they have been influenced by past experiences. *Education* is a modification of unlearned activities based upon past experiences and memory.

Emotions are the organic expression of the *instincts.* They may be of short duration such as fear, anger, joy, or of longer duration such as anxiety, worry, depression, resentment, disappointment, ugliness or happiness. The latter are called *moods* or *temperments.* Hippocrates classified man into five groups based upon these temperments.

The reaction of different persons to the same environment or circumstance is dependent upon their inherited variations and upon their various past experiences. Alexander[1] cites an example as that of a large audience viewing a play or movie, in which some may laugh, some may weep and some may remain unmoved by certain touching scenes. These conditioned psychophysical mechanisms may explain the likes and dislikes, customs and habits of families and countries.

Mechanism of Psychosomatic Disorders

Every wish or psychic tendency seeks an adequate bodily expression: such as fear-run, anger-

fight, grief-weep, joy-laugh, desire for wealth or fame-ambition, desire for children (perpetuation of the species instinct)-sex and marriage.

If this external expression of a psychic desire is blocked, a sort of short-circuit or switching of the stimulus takes place in the hypothalmic centers into the wrong nerve tract and hence the emotion or desire finds its expression in some other part of the body with which these centers are connected. A simple example would be in case of fear of an examination or speech or unusual ordeal, in which the desire to walk or run away gets switched from the legs to the bladder, stomach or colon and is manifest in that organ. More continuous fear, anxiety or anger, or disappointment with environment, job, boss or marital partner may cause a more continuous chronic stimulation of various parts of the involuntary system. I know one woman who gets diarrhea whenever she finds lipstick on her husband's handkerchief. Another person, who works as a lecturer, usually has nausea and vomiting before each appearance. Such instances could be multiplied.

Diagnosis

A psychoneurosis should be recognized by the definite characteristics of abnormal behavior rather than by making such a diagnosis entirely by exclusion. Modern descriptive dynamic psychiatry classifies these conditions according to the predominating symptoms. During the process of routine history taking and examination, a doctor has an excellent opportunity to appraise the patient's emotional status without the patient being aware of such a psychiatric examination. It must also not be forgotten that many patients are likewise appraising the doctor during this procedure. Most patients are seldom solely somatic or solely psychic, it is usually a question of how much of one or the other is present in the individual patient. A patient may be somato-psychic as well as psychosomatic, in other words, he may be sick mentally because of some organic lesion, anemia, vitamin deficiency, chronic poisoning, cancer, et cetera, as well as because of emotional instability.

Some of the things which characterize a neurosis are: (1) the patient's pain or discomfort does not conform in location or radiation to any definite physical condition. (2) The symptoms are changeable and shifting. (3) They are worse on emotional stimulation. (4) There is undue fear, anxiety and apprehension. Patient may ask for a diagnosis and opinion before the examination has been started. (5) History discloses previous abnormal adjustment and reaction to environment. (6) There may be peculiarities of expression, circumlocution or a refusal or inability of expression. (7) There may be joy, excitability, depression or irritability. (8) Peculiarities of thought, snapjudgments, or strong likes or dislikes, or food fads. (9) Abnormal drug reactions, such as immediate stimulation from a small dose of thyroid or iron. (10) Abnormal suggestability. (11) Fixation of attention on certain symptoms, such as air swallowing or heart palpation. (12) The history usually shows that the current difficulties are only repetitions of earlier basic patterns of maladjustment.

Treatment

Psychotherapy offers no miracles even in the hands of experts, popular articles written by psychiatrists for public consumption notwithstanding. The following procedures outline the things which have been found to be of greatest value in helping the nervous patient.[7,10,11,16]

Reassurance.—A meticulous and complete medical examination is necessary, including a careful history, physical examination, laboratory and special tests and x-ray studies. These should be repeated if necessary often enough to reassure the doubting patient and also often enough to convince the doctor that nothing has been overlooked. A large number of patients originally diagnosed as pure neuroses are later shown by repeated examinations to have some somatic disease which had been previously less manifest. I disagree with the psychiatrists who say that one examination only should be done else the patient gets a fixation on his internal organs.

General medical treatment should be carried out in an effort to bring the patient to the best possible state of well being. Proper regulation of exercise and rest, adequate hours in bed, a well-balanced diet, control of excessive smoking, drinking, and coffee, as well as medical treatment of anemia, vitamin deficiencies, infections and thyroid or menopause disturbances. Inferiority complexes may be caused by such defects as sinus trouble, nasal obstruction, bad teeth, hemorrhoids, varicose veins, moles on faces, et cetera. Nonessential surgery should, however, be avoided.

Re-education is stressed in modern psychotherapy. Explanation should be made to the patient regarding the mechanism by which blocked psychic emotional tendencies or desires may cause nervousness, conversion and psychosomatic reactions. The adversities in the patient's life which are causing trouble may not always be revealed or may be concealed in the patient's history. Frequently, when the patient has been convinced as to the mechanism and cause of such symptoms, he himself will recall earlier life episodes or troubles which have persisted in the subconscious mind. Thus he may see the foolishness of his present symptoms. The patient should be taught to ignore minor symptoms and they will disappear.

Sublimation.—Energy which is usually permitted to run wild is put to some harmless entertaining, educational or social use. The list includes sports, literature, scrapbooks, photography, travel, astronomy, geology, biology, club work, religion, sewing, painting, et cetera. This method of psychotherapy is most important, but only brief mention can be made at this time. It includes subjects necessary in the art of living and helpful in smoothing troublesome mental adjustments. Its possibilities and study prove of value to the physician as well as to the patient.

Environmental Change.—This is often desirable and feasable. Patients should be advised to change jobs and find suitable and likable work at times. Perhaps a move to a different location or climate may be indicated; advice may be needed regarding living within income, marital trouble or the use of contraceptives. Some problems, however, are insolvable.

Relaxation.—Most patients with psychoneurotic reactions are tense and anxious. They should be taught and urged to relax at every opportunity. A routine of frequent rest periods may be necessary, together with ten to twelve hours in bed each night. Urge the value of masterly inactivity and everything connected with the philosophy of life expressed by the phrase that things won't matter much 100 years from now.

Confession.—Patients should be urged and allowed to talk out their troubles. It is a form of mental catharsis, and often gives relief. Their physician may be the only person in whom they have confidence enough to tell their intimate problems and seek advice. Some doctors know best how to handle such unhappy human beings; others do not like such patients and are inclined to give them the brush-off. The patient should always receive the impression that the doctor is his friend and anxious to help him in every way.

Suggestion.—This form of psychotherapy is of great temporary value while studying the emotional problems of the patient, but should not be carried beyond a certain limit, into the field of clairvoyance.

Psychoanalysis.—This procedure is not very practical because the patient must be young and physically healthy, be above average intelligence and have plenty of time and money, as the necessary conferences require one or two hours, two or three times per week for one or two years. Recently a method has been used to shorten the time necessary to uncover unconscious sources of anxiety. It is called narcosynthesis and consists of giving narcotics to the point of depressing the cortex and the hypothalmus simultaneously without producing sleep, and then using word association and other psychoanalytic methods.

Shock Therapy.—Experience shows that electroshock is of great value in the depressive states, but has limited value in most other neuroses or psychoses. It should be used only by a psychiatrist trained in its indications and procedure. Other forms of shock therapy such as produced by metrazol or insulin have been mostly replaced by electroshock.

Summary and Conclusions

The psychoneurotic problem is today one of the biggest problems in the country. The problem is beyond the ability of the psychiatrists to handle unaided by the rest of medicine. General medicine has failed to understand and take sufficient interest in the subject, chiefly because of the lack of "rapport" and the poor presentation of the subject by the psychiatrists.

A working outline of the subject based upon a perusal of psychiatric literature, as seen by an internist, has been herein presented. Abnormal behavior may be somato-psychic as well as psychosomatic. Many authorities believe that biochem-

istry will eventually play a big role in solving psychiatric problems.[9]

Knowledge of the methods of recogition and treatment of the psychoneuroses should be a requirement and more generally understood by every physician.

References

1. Alexander, F.: Functional disturbances of psychogenic nature. J.A.M.A., 100:469, (Feb. 18) 1933.
2. Alvarez, W. C.: Gastrointestinal hypochondriacs. Gastroenterology, 2:265, (April) 1944.
3. Alvarez, W. C.: Small unrecognized strokes. J. Michigan M. Soc., 43:389, (May) 1944.
4. Bauer, Julius: Constitution and Disease. New York: Grime and Stratton, 1945.
5. Bennett, A. E.: Faulty management of psychiatric syndromes simulating organic disease. J.A.M.A., 130:1203, (April 27) 1946.
6. Burlingame, C. C.: Hard facts about psychiatry. J.A.M.A., 113:377, (July 29) 1939.
7. Dunbar, F.: Psychosomatic Diagnosis. New York: Paul B. Hober, Inc., 1945.
8. Fetterman, J. L.: The correlation of psychic and psychosomatic disorders. J.A.M.A., 106:26, (Jan.) 1936.
9. Freeman, W.: Psychochemistry. J.A.M.A., 97:293, (Aug. 1) 1931.
10. Levine, M.: Psychotherapy in Medical Practice. New York: Macmillan Co., 1943.
11. Masserman, J. H.: Dynamic Psychiatry. Philadelphia: W. B. Saunders Co., 1946.
12. Moore, Merrill: The Psychiatric Approach. Pullens' Medical Diagnosis. Philadelphia: W. B. Saunders Co., 1944.
13. Palmer, Walter L.: An Internist Looks at Psychiatry and Psychoanalysis. New York: The National Committee for Mental Hygiene, Inc., 1944.
14. Ranson, S. W.: Anatomy of the Nervous System. Philadelphia: W. B. Saunders Co., 1935.
15. Vonderahe, A. R.: The representation of visceral function in the brain. Ohio State M. J., 31:104, (Feb.) 1935.
16. Weiss, E., and English, O. S.: Psychosomatic Medicine. Philadelphia: W. B. Saunders Co., 1943.
17. White, J. C.: The Autonomic Nervous System. New York: Macmillan Co., 1937.

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WHY READ THIS JOURNAL?

This is your journal and if you do not read it, you are that much poorer, Doctor, than you would have been if you had taken the time necessary to improve yourself.

Most of the younger members of our profession realize that they do not know all there is to know about the medical profession and they will go a long way toward improving themselves, but there is a small number of our young members who think more of a cocktail party than they do of their State Medical Society and its outstanding *Rocky Mountain Medical Journal.* There is not a state medical journal published that is as valuable to the medical profession of the Rocky Mountain States as is our own *Rocky Mountain Medical Journal,* and it should be the first journal we read.—Editorial (E. W.) *Rocky Mountain Medical Journal,* September, 1947.

COMPULSORY HEALTH INSURANCE

In the Congressional Record of June 17, 1947, Page A-3087 will be found the remarks of the Hon. Robert A. Grant, congressman from Indiana. He said:

"European collectivism is aggressive in every sphere of American life, but nowhere is it more threatening than in the national campaign to fasten upon us a system of socialized medicine. This program did not originate in the United States, but in the secret council of world communism. It would reduce our doctors, dentists and nurses to Federal payrollers, responsive first to a new Federal bureaucracy."

Psychiatric Sense and Nonsense

A Review

IN THE LAST and concluding paragraph of his article, "Psychiatric Sense and Nonsense," published in the April 5, 1947, issue of the *Journal of the American Medical Association,* the author, Dr. C. C. Burlingame, chairman of the Committee on Public Education of the American Psychiatric Association, expresses the most important thought of the entire article, which, because of its significance, I quote:

"Most important of all, the psychiatrist must express himself in terms which can be understood by every medical practitioner, and pschiatry must be made an integral part of medicine. It does not take a great mind to make simple things complicated, but it takes a very great mind to make complicated things simple. Let psychiatrists, then, distinguish between psychiatric sense and psychiatric nonsense and bring simple, hard-headed sense into this field, which contains the greatest public health problem of the world today."

The amazing thing to this reviewer is the fact that here is a doctor who takes his own medicine. His article is presented in such a straightforward manner, simply expressed, easily understandable by any and every medical practitioner, that it is almost an anomaly in present-day medical literature. His only deviation from direct presentation is in the few statements in which reference is made to certain restricted fields of therapy, which he diplomatically refrains from calling by their known names.

What is presented is not new—although his reference to re-educational therapy might appear to be new to those not fully versed in psychiatric thought and training, and even to some of those in the field. There is, however, the constant forceful, direct presentation of these fundamentals in the manner that he propounds—which makes the article live up to its title.

Some of the points he stresses in so practical a manner, and worth reiterating here in brevity, are:

1. "It is psychiatric nonsense to claim that present-day psychiatry contains the cure for all the mental ills to which the human flesh is heir."

2. "It is psychiatric nonsense to claim that if psy-

This paper is reviewed by Martin H. Hoffmann, M.D., for the benefit of our readers at the suggestion of the Committee on Mental Hygiene of the Michigan State Medical Society.

chiatry only had a chance a vast majority of psychiatric breakdowns could be prevented."

3. "It is . . . true that, with comparatively few exceptions, he (the psychiatrist) does not know the cause of so-called mental diseases."

4. "I doubt if the endless papers describing these conditions are getting at the fine point of establishing disease entities, and the establishment of disease entities must antedate any truly scientific exploration into the causes and prevention of mental diseases."

In reference to present-day shock therapy, he iterates:

"Only a stupid person would decry shock therapy as an instrument in helping the mentally ill, but, nevertheless, one should not condone the use of shock therapy for everything from an ingrowing toenail to baldness. The seemingly miraculous results obtained in the presence of shock therapy should not cause one to lose the wits with which one was born or the knowledge one has acquired in the past thirty or forty years. To proceed as if shock therapy, any more than any other psychiatric technique, can usurp the place of all other therapies is psychiatric nonsense."

He nicely expresses the unfortunate misunderstanding of so many when he states:

"Psychiatrists talk at great length about psychotherapy, which may convey a great deal to their own initiated group, but, in the minds of the general public, the term is more or less mixed up with metaphysics and the occult."

While he puts it importantly, he does not overstress the fact that: "Psychiatric patients must be examined from the point of view of the human mind and the human body and must be put in the best possible condition to meet life. In a word —they must be re-educated for living."

His psychological four-legged chair is a clever metaphorical way of picturing man's psychologic life. This chair is made up of four headings; viz., (1) man's vocational life, (2) his avocational life, (3) his social and recreational life, and (4) his physical self. As he puts it, "If it has four solid legs (rather than short, defective, or missing ones) he is destined to sit comfortably and securely throughout life." This cannot be mistaken—it is understandable—and depicts with clarity a sensible approach to a reasonable basis for interpretation of many of mankind's frailities.

At some length, he stresses what, I believe, is being understood daily by all medical practitioners —though he does not use the term—namely, psychosomatics. The constant interrelationship of body and emotions and their being mutually disordered, regardless of which is the primary sick area, is almost universally accepted and dealt with today.

He could nicely have connected and united several sentences which are widely separated to impress that a certain of the newer concepts should be self-restraining and not all-inclusive, as well as less authoritarian in claims and promulgations. They would then read:

"I doubt if merely talking with a patient, using so-called psychotherapy regarding hidden experiences which occurred to him at two or three years of age, is a practical solution to the problems of the hundreds of thousands of psychiatric patients. More is known about the course of the so-called mental diseases than about their causes.—Theories and hypotheses are stimuli for research, but theories and hypotheses based on other theories and other hypotheses are not scientific facts. If the psychiatrist is lost in a morass of theory, there is great danger that his idea of scientific advances will drift into the sphere of wishful thinking and fairy tales."

There will righteously be many who will take issue with his statements relative to involutional melancholia. That statement, though brief, may be slightly too dogmatic and lays itself open to too much possible difference of opinion, to be passed by uncriticized.

This dynamic paper is a literary replica of the straightforward, energetic personality of its author. "Burly," to those who know him intimately, has struck the keynote and the right tempo for others to follow in psychiatric education; less of polysyllabic pedantries and pompous prolixities and more of sound sane sense in understandable writings will help the progress of psychiatry as a whole, and do much toward bringing a proper interpretation of and relief to the sufferers for whom it means so much.

Deserving of the highest commendation, and well worth reading, this interesting paper should be a "must" on the reading list of every practitioner of medicine, regardless of the field of practice in which he may be engaged.

—Martin H. Hoffmann, M.D.

MSMS

The Bureau of Medical Economic Research of the American Medical Association reports that the American people spend two and one-half times as much for tobacco as they spend for physicians' services.

The Rise and Fall of Medical Incomes

Trends in Medical Incomes, Expenses, Taxes and Savings During the Past Fifteen Years

By Henry C. Black and Allison E. Skaggs
Battle Creek, Michigan

WHEN WE FOUNDED Professional Management in October, 1932, there were few statistics of any real value which could be used for comparisons with the experiences of the doctors whom we were serving. Since that time, much has been written on the general subject of the economics of medicine, some of it dealing with the social and political aspects, some dealing with the various medical prepayment plans and the figures used in the attempt to predetermine what these plans would cost, and, in our opinion, far too little on the actual financial problems confronting the doctor in private practice.

Some commercial organizations, through questionnaires, have computed average income and expense figures on what would appear to be average practicing physicians, and the results have been published from time to time. Government agencies, and groups affiliated with organized medicine, through their own investigations, have made statistics available which have been of doubtful accuracy because compiled from questionnaires filled out by doctors who either (a) by virtue of a low volume of business had plenty of time to fill them out carefully; (b) had inadequate records; or (c) who depended upon estimates prepared by employes.

Our previous reporting of medical incomes,[1,2,3] of course, has failed to indicate the income of the *average* physician, inasmuch as our only source was records of our clients. They are, however, representative doctors in their communities, and generally have higher than average incomes. The accuracy of the figures can hardly be questioned, as they were copied from complete records, in which all income and expense had, to the best of our knowledge, been recorded. With a minimum of necessary substitutions, we have used the figures of the same fifty doctors on whom we reported in previous articles, so as to minimize variable factors. In analyzing the rising costs of operating an office over a period of years, we consider such a constant sampling to be imperative, so that ratio changes in expenses and income are significant.

TABLE I. DR. "COMPOSITE"—INCOME, EXPENSE, WITHDRAWALS, AND TAXES
1946

		Per Dollar
PROFESSIONAL INCOME		
Total Charges to Patients	$34,027.00	
Total Cash Receipts	33,403.47	1.00
98% collected		
PROFESSIONAL EXPENSES		
Rent, Heat and Light	1,089.55	3.2
Drugs, Medical Supplies	2,214.74	6.6
Salaries	4,118.36	12.4
Car Expense (incl. depreciation)	912.10	2.7
All Other Professional Expenses	3,605.72	10.8
	$11,940.47	35.7
PROFESSIONAL PROFIT (before taxes)	$21,463.00	64.3
Federal Income Taxes	7,233.53	21.7
Actual Profit (after taxes)	$14,229.47	42.6
Living Expenses (including interest, real estate taxes, contributions)	9,308.97	27.9
	$ 4,920.50	14.7
Life Insurance Premiums	2,289.38	6.8
BALANCE FOR SAVINGS OR INVESTMENT	$ 2,631.12	7.9

In view of the fact that actual cash receipts per doctor in 1945-1946 were almost identical with the 1944 figures already reported in THE JOURNAL,[3] it might seem that the reporting of these more recent figures would serve no useful purpose. On the contrary, however, startling changes in expenses, living costs, and taxes make the study of present net incomes, and the factors contributing to them, quite pertinent since we must be prepared to pay much higher than prewar taxes for many years to come. The continual rise of gross incomes characteristic of the war years is now a thing of the past, and may actually be reversed in the next year or two by less favorable general economic conditions, so it behooves all doctors to inform themselves immediately as to expense ratios, living costs and probable surpluses. *Operating costs are still rising,* living expenses are the highest on record, and with high taxes and low "take home pay," doctors should adjust, not to a temporary situation, but to a condition which may persist for years.

The figures of our composite doctor represent 1/50th of the total income, expense, income tax, living expenses, et cetera of the fifty men previously mentioned. We have comparable figures on the same practices for each year since 1939, and, surprisingly enough, the ratio of expense to income is fairly constant, whether in the lower or higher incomes. The averages are shown in Table I.

To emphasize the changes which brought about

TABLE II. RATIO OF EXPENSES AND WITHDRAWALS TO INCOME FOR VARIOUS YEARS

	1939	*1941*	*1944*	*1945*	*1946*
INCOME	$1.00	$1.00	$1.00	$1.00	$1.00
EXPENSES:					
Rent	6.0c	3.9c	3.0c	3.2c	3.2c
Drugs	11.0	6.4	6.5	6.3	6.6
Salaries	10.0	7.6	10.2	11.2	12.4
Car	5.0	3.7	2.8	2.7	2.7
Other	12.0	15.4	9.7	9.8	10.8
Total	44.0	37.0	32.2	33.2	35.7
PROFIT	56.0	63.0	67.8	66.8	64.3
Less Federal Income Tax	3.0	4.0	23.6	27.7	21.7
AVAILABLE FOR LIVING EXPENSES AND SAVINGS	53.0	59.0	44.2	39.1	42.6

TABLE III. AVERAGE INCOMES AND EXPENSES

1939 and 1946

	1939	1946
Business Done	$13,647.60	$34,027.00
Cash Received	12,049.51	33,403.47
Expenses:		
Rent	693.96	1,089.55
Drugs and Supplies	1,283.16	2,214.74
Salaries	1,227.32	4,118.36
Car (including depreciation)	648.55	912.10
All Other	1,445.13	3,605.72
Total Expense	$ 5,298.12	$11,940.47
Profit before Taxes	6,751.39	21,463.00
Income Tax	440.00	7,233.53
Net Profit after Income Tax	6,311.39	14,229.47
Living Expenses (including interest, taxes, contributions)	4,700.00	9,308.97
BALANCE FOR LIVING AND SAVINGS	1,611.39	4,920.50

the above result we have prepared two more exhibits, Table II showing the amount of each dollar of income spent for various expenses during representative years, from 1939 to 1946, and Table III showing the dollar increases which have occurred between 1939 and 1946. (The 1939 figures differ from those reported in a previous article[3] because of necessary substitutions for 1946.)

From these tables, it becomes increasingly apparent that net incomes after taxes are deducted are not as much higher as might be expected; that living costs are almost double; that old-fashioned thrift is still important; that if economic conditions change as is to be expected, it will be imperative that all doctors be currently informed, if they are to benefit as they should from their long expensive training and for the long hours they spend in the practice of their profession. Net gain, after income taxes, living expenses, and life insurance are deducted, amounted to $2,631.12 in 1946 as compared with $1,025.55 in 1939. This is surely a small return for doing $18,000 more business, and the net gain actually *decreased* from 9 per cent of business done in 1939 to less than 8 per cent in 1946.

An analysis of the expenses in Tables II and III indicates some trends which will become more and more important if incomes decrease.

Rents

Dollars spent for rent are *up* almost 50 per cent, while the percentage of income spent for rent is *down* almost 50 per cent. As the volume of business is not expected to decrease substantially in the next few years, and as renting in most cases is still less expensive than the cost of construction and maintenance of similar quarters, it would seem that this item may be passed over with little comment.

Drugs and Supplies

The decrease in cost of drugs and supplies shown in Table II, which has been fairly consistent since 1940, indicates a trend toward prescribing rather than dispensing. The use of more expensive drugs and the substantial increase in drug prices would account for the slight increase in 1946, although the rate of increase in the cost of drugs during the 1939-1946 period is not reflected due to the reason previously stated.

Salaries

The only office expense item which has gone up faster than has the income itself is salaries, and this is occasioned not only by the use of additional personnel, but also by the *increase in rates paid per employee.* In a confidential study recently completed for our clients, the rates paid the individual personnel were compared year for year since the period before the war and showed a consistent increase of 10 to 18 per cent a year for the past six or seven years, with the greatest increase in 1943-1944-1945 and an increase of as much as 10 to 12 per cent in 1946-1947. It may be that the peak has now been reached, but the extreme shortage of office personnel in many areas has a tendency to keep the wage trend upward.

Car Expenses

Average costs of operating an automobile vary in many ways. During the war years the allowable depreciation on the business car was often used up long before a new car was available, resulting in lowered depreciation costs, but accompanied by much higher costs of repairs and tire replacements. The figures tend to show, however, that frequent trades in peacetime resulted in higher operating costs than did the less frequent trades during recent years. However, the

convenience and dependability of a new car usually are considered to have justified the slight additional cost.

Total Operating Costs and Profit Before Taxes

We believe that the percentage of overhead expense of *these* physicians is about the same as that of most others practicing in Michigan. The dollar profit, however, was probably higher because, even before the war, we were advising them to get more efficient space, better equipment, and more adequate personnel, so that, in the early days of the tremendous increase in business, most of our clients were better prepared to handle it, and, as a result, had a greater increase than did many of their colleagues.

One word of caution! Overhead is a word often used carelessly, and if not all-inclusive, can be very deceptive. For example, many doctors have told us their "overhead" did not run over 25 to 30 per cent, when they were including only direct cash expenses and not considering depreciation on their capital investment such as equipment, instruments, automobile and office building. The 40 per cent overhead commonly considered as average back in the "thirties" was commonly higher, as evidenced by our figures for 1939. At the same time, certain types of offices still have all-inclusive overheads as low as 25 to 30 per cent. Group practices and partnerships of two to four partners frequently show overheads as high or higher than do individual doctors,[4] but the increased overhead sometimes more than pays for itself in additional dollar revenue.

Federal Income Tax and Profit After Taxes

Back in the "thirties," net income *before* taxes was only slightly higher than net income after taxes, but with the tremendous increase in Federal Income Taxes during the war years, the latter "take home pay" is the only figure that can be used to determine what to do with profits. Comparing a net profit of 42.6 per cent after taxes with one of 64.3 per cent before taxes makes one realize that in 1946 the doctor was merely acting as a "trustee" for one-third or more of his net profit. What he really had left for living expenses and to provide for his old age was the other two-thirds or less of his profits that remained after having sent substantial payments to the Collector of Internal Revenue, *fifteen days* before the end of the quarter in which they were earned. Fortunately, errors in business judgment, exorbitantly high office expenses, et cetera, are deductible before taxes, if interpreted by the Revenue Department as necessary expenses, but any extravagances after taxes are paid are not so discounted, and *become more and more dangerous as incomes increase.*

Many of our clients in the higher income brackets have finally realized that their share, after taxes, of their top income dollar is less than the inevitable rise in living costs which always seems to accompany such increases in income.

Living Expenses

Fifteen years of helping doctors with personal and business problems, taught us long ago that any attempt to control personal and household expenses must be done with finesse and caution. How much is to be spent for living expenses should be determined by the individual doctor and his wife, but the average of our clients runs over $9,000.00 per year, approximately 28 per cent of the total income or about two-thirds of the net income after taxes.

With life insurance and annuity premiums running another six or seven per cent of gross income, or one-sixth of net income after taxes, it would appear that the family is usually well provided for in case of untimely death, and the general idea that doctors are heavy purchasers of life insurance seems to be well founded.

There are many conflicting opinions as to how best to invest surpluses so as to provide a maximum of security for old age. Some conservatively advocate depositing most of them with life insurance companies or purchasing Government Bonds, while others advise investing substantially in common stocks or real estate. A middle-of-the-road course usually seems preferable to us, and either extreme should be the exception rather than the rule. In general, until a substantial fund is available for investment, it is difficult to invest primarily in common stocks with a sufficient degree of diversification to provide a well-rounded program, although the purchase of investment trust shares offers a way to overcome this difficulty. As we have so often pointed out before, good counsel is desirable whether the problem be one of investment, insurance protection, taxes or business management. Just as the wise patient first goes to his doctor rather than trying out

(Continued on Page 1222)

Membership

The Michigan State Medical Society now has 4,536 members. This is truly a strong organization with 4,536 members working harmoniously together for the common good of the public and our profession. However, there are still many eligible Doctors of Medicine in Michigan who do not belong. Let's make an all-out drive for membership this year.

This must be done at the county level for, as you know, a man can become eligible for the Michigan State Medical Society and the American Medical Association only through membership in his local County Medical Society.

The officers of each of our fifty-five County Medical Societies are hereby urged to appoint a Membership Committee, and to see to it that through this committee every reputable Doctor of Medicine living or practicing within the boundaries of that County Medical Society is cordially invited to join. The advantages of membership in organized medicine are many. Our aim should be 100 per cent membership in 1948.

P. L. Sedwidge

President, Michigan State Medical Society.

President's

Page

Editorial

POLITICAL MEDICINE IN JAPAN?

PRESIDENT TRUMAN chose Sunday, August 31, 1947, for another of his releases of four-point labor and social legislation programs for next year, which he labeled a "Must." The four points are: (1) Broadening of the social security system; (2) raising the minimum wage rate; (3) establishing an adequate health insurance system; (4) restoring labor department jurisdiction over all government functions relating to the welfare of wage earners.

By a strange coincidence this was preceded, by only a comparatively few hours, by a radio announcement of the departure from Washington of a Commission to go to Japan to set up a National Health Service. The War Department announced this mission as being sent at the request of General Douglas MacArthur. The members who departed by air, August 28, 1947, were Dr. Joseph W. Mountain and Mr. Barnet M. Davis of the United States Public Health Service, Mr. Barker S. Sanders, Social Security Administrator, and Mr. Francis A. Staten, Public Housing Administrator. These will be followed at a later date by Mr. Arthur J. Altmeyer, Commissioner, Social Security Administration, and two others not named. This constitutes the high brass working as a front for Falk, Wagner, et al.

Is Japan to have a Wagner-Murray-Dingell plan thrust upon her by force of military victory and occupation?

MEDICAL INCOME

FROM EVERY SIDE we are told of the high incomes of doctors of medicine, and frequently we see a report of a questionnaire, or the estimate from a survey, all tending to show high income. We believe many doctors themselves think the average medical income is in relatively high figures. In this issue of THE JOURNAL is an article entitled "The Rise and Fall of Medical Incomes," written by the men who fifteen years ago organized and have operated Professional Management. It presents such a "down to earth" analysis of medical economics that we are prompted to invite your attention to it.

These figures must be accepted as representative of the income of the medical man during the times mentioned. They have actually been taken from the books of an average group of fifty men, and they come from bookkeeping where the methods and activities are expertly checked every month. How many of us appreciate that a total cash income of $33,403.47 shrinks to an investable amount of $2,632.12?

Such an accurate and locally significant comparison of income and overhead, accompanied by conservative counsel, can be of inestimable value in stabilizing income and assuring continued prosperity. Surely one of the ways of combatting the ideologies of the "lunatic fringe," and the domination of an honored profession by "big government," is to get our own individual "houses" in order.

The fact that medical men should and do place the lives and health of their patients above personal gain is NOT the reason why we continue to hear that old adage "The Doctor is a Poor Business Man." It is because so many of our profession *are* careless or ignorant of ordinary business records or routines. The sooner we correct this condition the less ammunition the foes of organized medicine will have.

PRACTICE BY APPOINTMENT

CRITICISM of the individual members of the medical profession is encountered in every survey and testing being done to find answers to problems of public relations. Laymen complain that "they are being pushed around by the doctors." Just today we were told of a patient trying to find a doctor in one of our larger towns. The patient had an earache too severe for ordinary remedies, but could only see the otologist by appointment, and the first available date was two weeks. Too often the doctor's appointments are made up as far as six weeks in advance.

Industrialists complain that if a worker has to go to a doctor during working hours it takes at least three hours, and causes too many lost man-hours. And the patients that do get in to see the doctor complain that the appointment is

crowded into so little time that they feel as though they are on an assembly line.

Tens of thousands of our doctors have returned from military service where they became used to fixed hours, and shorter hours for their work. Labor and the government have impressed upon all of us the ideal of a forty-hour week. Doctors, especially the younger ones, are adjusting their practices to short hours filled with appointments, and these are made far in advance. Such a regime makes for the complaint that doctors are hard to find; that there are too few of them.

During the war many of our busy doctors found that they were not rendering the best possible service by the appointment system, and opened their offices to all comers; first come, first served. The office doors would be closed at a designated hour, and the doctor would care for all that remained before leaving. People complained of having to wait sometimes a long while, but they did get medical care. This plan should appeal to some doctors in each community.

If doctors continue to practice by appointment, and since the public is really entitled to medical attention, we would suggest that every day of appointments include one hour or a specified time for patients without appointments.

WHAT OF OSTEOPATHY?

GRADUATES OF OSTEOPATHIC schools from other states (we have none in Michigan), are flocking into our state in great numbers, there being now about nine hundred and thirty here. Under their claims of practice they are working in every field of medicine and surgery. To the extent of their numbers they have already taken over much of general practice, and some surgery. We now have a situation that has been thrust upon us by circumstances beyond our control. Clarification of this situation is needed, and is being demanded by groups and by individual doctors, administrators and others interested.

We know that doctors have not yet agreed on the program that must ultimately evolve, and that any suggestion made will not meet with full approval. However, we are suggesting a solution that we believe would work, and would be acceptable to the majority of the medical profession, and also to the osteopaths. By making our suggestions, we are not recognizing the osteopathic philosophy of practice. Osteopaths themselves by their very practice are repudiating the basic principles laid down by their founder, Still. Practically none of them is practicing "osteopathy." They have come as far as possible back into the fold of medicine, what used to be called "regular" medicine.

We suggest that our two medical schools, and there is none better, establish Chairs of Osteopathy; some have suggested that they be called "Physical Medicine," but we prefer direct methods. Those taking the course could be graduated with either the medical or the osteopathic degree, or both. That is not important. What is important is that we could then establish standards of education for any osteopaths who wish in the future to come to Michigan. Those already here would not be affected. In future, underprepared men would be excluded, which would be a direct advantage to those already in practice. The treatment our people would receive in the future would be from fully competent, well-prepared practitioners.

These graduates could be taken into our societies if they wished. Those now practicing could be given postgraduate courses which would bring up their requirements, and in time they also could qualify for practice in the larger field, and hold their medical society membership accordingly, under limitations to be established.

Most medical men with whom we have talked are coming to believe that an "absorption of osteopathy" must be made in time, the same as was the case with homeopathy during the first years of the century. They believe such an assimilation would solve many present problems. Medicine has had her experience with homeopathy, which in its way was just as disturbing as the present problem. There was the same animosity between the two groups. We do not advocate "absorption." We advocate cure.

In the past the medical profession has condemned the osteopath as a poor doctor but we recognize that he is going to stay in our community. We are now definitely excluding him from the possibilities of our postgraduate training and improvement. The M.D. with his training and his postgraduate courses should never fear competition of an inferior quality.

A program such as we have suggested would assure well-trained practitioners, would assure better care and better health to the people, would elevate the standards of the "osteopathic profession," and would, we believe, be workable.

MEDICAL P.R. IN COLORADO

"REPORT on Public Relations to the Colorado State Medical Society" is the title of a copyrighted brochure printed by the Colorado Medical Society which contains the recommendations of Raymond Rich Associates, New York, for a positive public relations program for the Colorado Medical Profession.

Briefly, this excellent report refutes the idea that all the medical profession must do, to keep its lay friends, is to "practice good medicine." The report states that "the public expects private medicine to exercise leadership in all matters which pertain to the community's health. . . . They (the people) do not consider doctors 'reactionary' so much as politically and socially 'illiterate,' and they hope for their enlightenment."

Aside from every doctor of medicine keeping up with his swiftly moving science by taking necessary postgraduate continuation work, the following positive public relation action on the part of the individual practitioners is urged:

1. Courtesy to patients.
2. Sympathy to patients.
3. Explanation to patients—making sure they understand the necessity for such treatment as the doctor prescribes for them.
4. Fairness in fees.
5. Leadership by the medical profession, both collectively and individually. "The faculty of initiating action may be called the life-blood of good public relations."

"Gripes" of the public, indicating abuses that must be corrected, are as follows:

1. Abuse of fees. "The few individuals who overcharge are giving the medical profession a bad name with the public. . . . One erring brother will do more harm to the group's reputation than the exemplary conduct of a hundred others can readily counteract."
2. Unethical conduct (including the incompetent and the over-operators).
3. Keeping patients waiting unnecessarily long.
4. "Assembly Line" service.
5. Rudeness or unnecessary hastiness on the part of receptionists, technicians, assistants or nurses.
6. Ostentatious display of financial success by the doctor—owning the biggest house, the largest car, power boat, et cetera, et cetera.

The report ends with a number of observations and recommendations, among the former being: "Enlightened conduct is the first requisite for good public relations . . . the second requisite is efficient operation—efficient administration of all the programs which represent enlightened conduct."

Leadership activity on the part of the county medical society (not alone the state medical socity) is the basis for a number of the report's recommendations. The need for friendly co-operation with helpful lay groups is stressed.

Finally, the effective publicizing of all public health activities of the county and state medical societies—so that their actions are graphically interpreted to the public—is urgently recommended. A basic precept of the Rich report is that doctors as a group have become increasingly isolated from the rest of the community. They do not now enjoy collectively the respect, appreciation and understanding which are their only real bulwarks against unfavorable future reactions to their profession. The report ends with details on how to do the big job of interpreting medical actions to the public.

Such a positive public relations program will result in eliminating hostility and antipathy to medical groups and in making new friends and keeping old friends for the profession, according to the Rich report.

Permission for quoting from copyrighted material granted to THE JOURNAL of the Michigan State Medical Society for the Board of Trustees, Colorado State Medical Society, by Harvey T. Sethman, Executive Secretary.

ON THE RUN . . .

The co-ordinative principle of science consists in the adjustment of each scientist's activities to the results achieved by others.

. . .

Pulmonary atelectasis following upper abdominal operations is best detected by x-ray twenty-four hours after operation.

. . .

Color-blindness occurs in about 8 per cent of males, is rare in females, and, like hemophilia, is inherited by male children from their mothers.

. . .

It is estimated that health insurance, with removal of economic restraint, may entail a rise of 50 per cent in demand for professional attention.

. . .

Relapses of penicillin-treated subacute bacterial endocarditis occur within thirty days of cessation of treatment and are rare after fifty days.

ALLERGY is recognized as a contributory factor in a wide range of conditions that exhibit puzzling diagnostic features. Foremost among the special tools of the allergist is the skin test which is indispensable in rounding out the diagnosis of the allergic patient.[1] In the interests of safety, simplicity, and economy, many clinicians prefer to make their skin tests by the scratch method.

Arlington Dry Allergens for Diagnoses

$35.00 SET—Specially selected assortment of 112 allergens including 83 foods, 10 incidentals, 9 epidermals, and 10 fungi in vials containing sufficient material for at least 30 tests each. The physician may make his own selection from our current list, which will be sent upon request.

$9.75 SET—Stock selection of 64 food and 16 epidermal and incidental allergens, in vials containing sufficient material for at least 10 tests each.

Each set accompanied by a supply of N/20 sodium hydroxide for use in making the tests.

Advantages of Dry Allergens:

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1. Feinberg, S. M.: Quart. Bull. Northwestern Univ. M. School 20: 398 (1946)

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Michigan's Department of Health

DEPARTMENT IS SEVENTY-FOUR YEARS OLD

Created when sanitary science was in its swaddling clothes, when the germ theory of disease was struggling for recognition, when most people believed in spontaneous generation of disease rather than in living contagion, and when the work of such men as Pasteur and Koch was just under way, the Michigan Department of Health observed the seventy-fourth anniversary of its founding July 30, 1947.

STUDY DEPARTMENT

Visitors from foreign states who studied the Michigan Department of Health, its organization and functions, during the month of July included: Dr. Joseph Hiltz, Divisional Medical Health Officer from Nova Scotia; Dr. E-Fen Chou, a technical expert in the Bureau of Maternal and Child Health, National Institute of Health, Chungking, China; Dr. S. P. Sinka, health officer from Ranchi, India; Dr. Victor Bertin of Chile, who will organize the first rural health department in that country, and Dr. M. Farooq of Hyderabad State, India, who will become public health director upon return to his native country. Another outside visitor was Mrs. Marjorie Abel, chief of the nutrition division of Hawaii's Board of Health.

WHOOPING COUGH TAKES LIVES

Whooping cough took the lives of thirty-three Michigan children during the first five months of this year. Eighteen of these deaths were of babies under six months of age. The remainder were of children under five years of age.

Whooping cough continues to appear with 6,431 cases having been reported to August 1 with 234 of them having been reported during the last week of July.

The Department through press and radio continually advises parents to have their children immunized against whooping cough. It tells parents how the disease is communicated, that it is serious, and that a physician should be called at once when symptoms appear.

MICHIGAN FARMING DANGEROUS

A quarter of the total deaths resulting from all occupational pursuits in Michigan result from farming. Agriculture remains among the most hazardous of all occupation pursuits.

Burns and explosions are among the most frequent and most fatal of all farm accidents. They take toll of children left alone in a farm home, of housewives who

(Continued on Page 1204)

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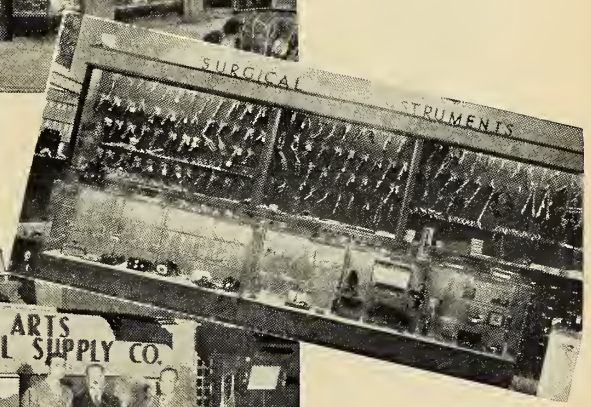

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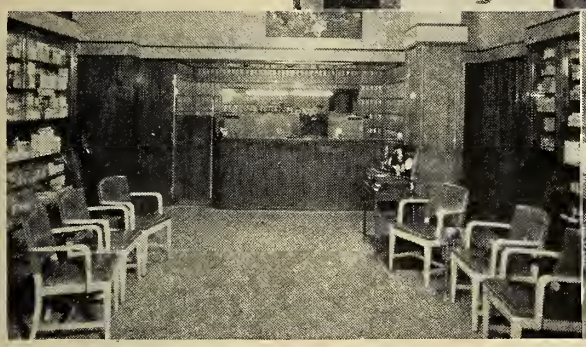

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MICHIGAN FARMING DANGEROUS

(Continued from Page 1202)

try to start a fire with kerosene or gasoline, of farmers who fight grass fires, who refuel overheated tractors, or who blast stumps.

Most dangerous farm machinery includes the farm tractor, truck, haying machinery, corn pickers, power saws, wagons and manure spreaders.

Falls, especially those from tractors, hay wagons and mows, down haychutes, and down cluttered or delapidated stairways, take many farm lives.

Horses cause more than half of the farm accidents related to farm animals and account for four-fifths of the deaths due to livestock. Bulls account for one-fifth of the deaths.

During Farm Safety Week, the Department called upon each farmer to make a list of hazards on his farm and to eliminate them, or, when elimination was impossible, to so educate his family and himself as to avoid them.

NATIONAL EXHIBIT

The Department was one of eight in the United States asked to prepare and display exhibits at the August meeting of the American Dental Association in Boston.

The exhibit of Michigan's program included photographs of such caries control research activities as the communal water fluorination experiment in Grand Rapids, the saliva testing service of the Department, and fact-finding clinics such as are being conducted in Sturgis school and by the mobile dental unit of the Department.

In educational fields, the continuing education program for dentists and allied professions, and educational work with lay groups of adults and children was depicted. The section dealing with treatment portrayed the part of philanthropic foundations, local health departments, the family dentist and his participation program in improving the dental health of the state.

PLAN TO CONTINUE PRODUCTION

The smallpox vaccine laboratories have been air-conditioned to make it possible to continue production of the vaccine during the summer months. This year, production which usually stops in April or May, will continue to September.

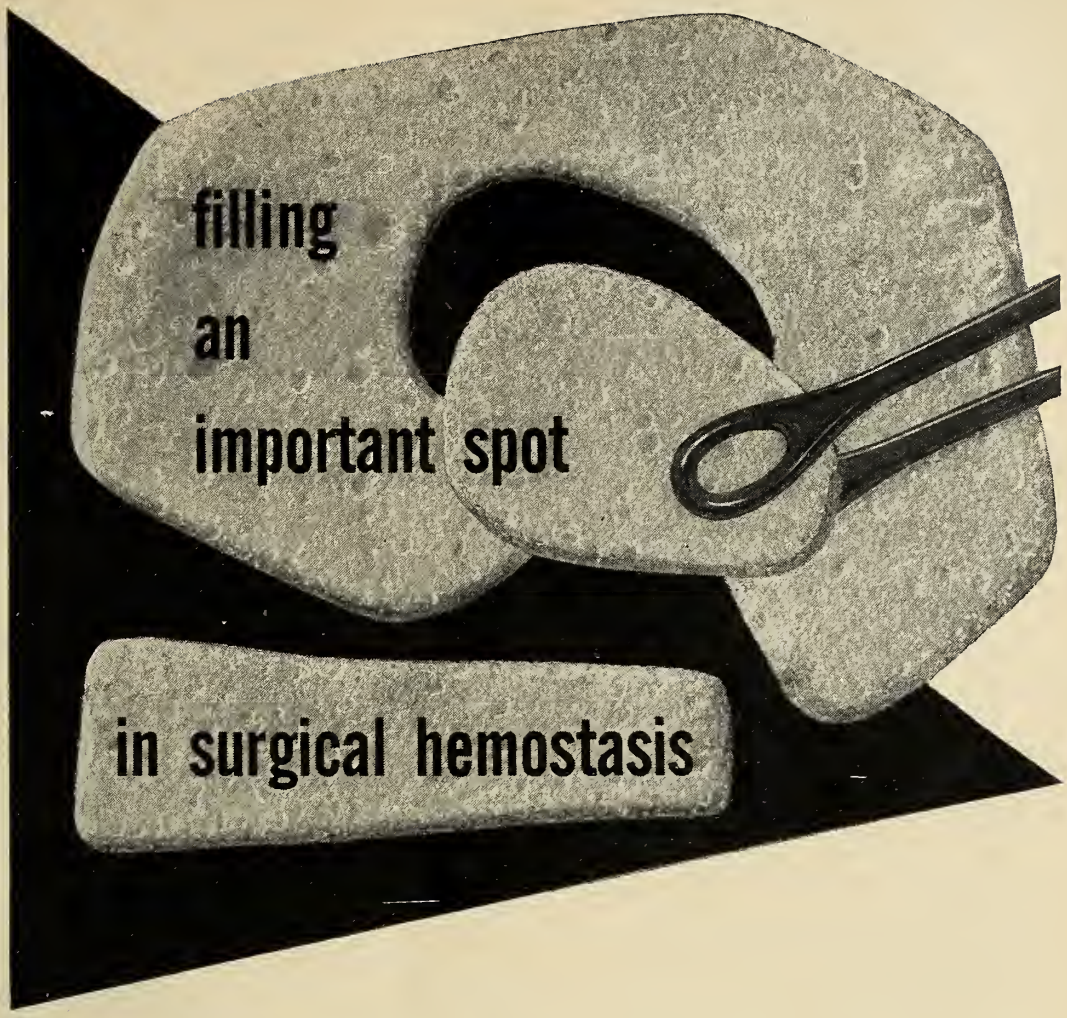
RHEUMATIC FEVER DIAGNOSTIC CENTERS

In "Michigan Public Health," in daily and weekly newspapers, and over the radio, the Department is calling attention to the rheumatic fever diagnosis program of the Michigan State Medical Society and the Michigan Crippled Children's Commission.

The Department pointed out the fact that rheumatic fever kills five times as many children as polio and cripples many times more than the paralysis. It outlined the symptoms of the disease, warned of its dangers and complications, and called upon parents to get suspected cases under the care of physicians.

(Continued on Page 1206)

Say you saw it in the Journal of the Michigan State Medical Society



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AMES COMPANY, Inc.

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(Continued from Page 1204)

SPECIMENS RECEIVED

Aware of the special Salmonella studies being conducted by the Department, the New York State Department of Health has sent the Lansing Laboratories several specimens for analyses for epidemic diarrhea.

UNDULANT FEVER

A detailed educational news release on undulant fever, its incidence, its symptoms, how it is contracted, and how to avoid it, printed in July, brought more than twenty requests for added information to the Bureau of Disease Control in less than one week. Those persons who said they believed they had symptoms of the disease were advised to contact their physicians for examination.

INCIDENCE OF COMMUNICABLE DISEASE

	July		*August*	
Disease	*1947*	*1946*	*1947*	*1946*
Diphtheria	4	32	7	31
Gonorrhea	1,046	941	906	1,209
Lobar pneumonia	39	57	33	42
Measles	470	869	190	173
Meningococcic meningitis	6	11	7	9
Pertussis	1,049	798	1,026	980
Poliomyelitis	26	73	134	318
Scarlet fever	186	208	115	112
Smallpox	0	0	0	0
Syphilis	1,186	1,608	1,149	1,480
Tuberculosis	543	517	628	549
Typhoid fever	6	24	6	19
Undulant fever	27	17	24	9

SYPHILIS IN MICHIGAN

Each month more than 1,300 Michigan persons contract syphilis and more than 900 others contract gonorrhea, according to reports filed in the Department's Bureau of Venereal Disease Control.

These reports indicate that it is possible that one out of every 250 of the state's total population will contract either syphilis or gonorrhea this year.

Between 1941 and 1946, syphilis infections among teenagers increased 270 per cent in Michigan.

DIPHTHERIA STATISTICS

Twenty years ago diphtheria took 516 Michigan lives; whooping cough, 210; scarlet fever, 235; and typhoid, 84—a total of 1,046.

In 1946, diphtheria was responsible for 27 deaths; whooping cough, 44; scarlet fever, 3; and typhoid, 6—a total of 80.

TUBERCULOSIS X-RAY SURVEYS

Mobile x-ray units of the Michigan Department of Health had twenty-two fairs on their schedules for the summer and fall months.

The Department x-rayed 17,682 persons at the first ten fairs the mobile units visited. In the first four of these fairs, sixty-seven cases of tuberculosis were dis-

Say you saw it in the Journal of the Michigan State Medical Society

covered. The fairs for which the reports are complete show an average of 11 cases of tuberculosis per 1,000 persons x-rayed in comparison with 15 cases per 1,000 x-rayed for the whole year of 1946.

At some of the fairs, the units x-rayed an average of one person per minute.

HEARING CONSULTANTS AVAILABLE

As an aid in conserving the hearing of Michigan's school children and to help those who are handicapped by poor hearing, the Michigan Department of Health is again this year offering the services of two hearing consultants to Michigan schools.

To find children with hearing difficulties, group hearing tests are given in the schools. An audiometer is used, and for those children found to have hearing loss, individual tests are made with a pure tone audiometer to determine the degree of loss. These children are then referred to their physician.

TYPHOID CARRIERS

Michigan's fifteen-year search for spreaders of typhoid fever has increased the total number of known carriers in the state to 265. In the same period the number of new cases of typhoid dropped from 424 in 1931, to 87 in 1946 and the number of deaths due to typhoid from 75 in 1931 to 6 in 1946.

FILM LOAN LIBRARY

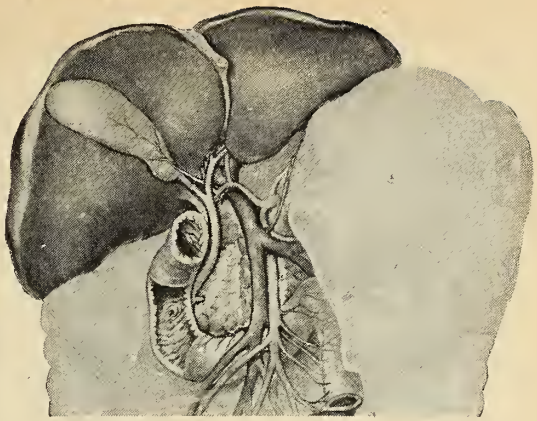
Motion pictures and film strips covering a wide range of subjects are available from the film loan library of the Michigan Department of Health. Records for the past year show 4,357 showings to a total attendance of 241,725 persons.

Motion pictures cover the following subjects: cancer, child health, dental health, diphtheria, dysentery, first aid, flies, food sanitation, hearing, history of medicine, immunization, industrial health, poliomyelitis, malaria, milk sanitation, nursing, nutrition, physical therapy, pneumonia, posture and walking, prenatal care, public health administration, rat control, safety, school health, sewage disposal, sight conservation, swimmer's itch, tuberculosis, venereal diseases and water supplies. Most of these are sound and some are color.

The thirty-five film strips available include sound strips on water, food handling, milk sanitation, rheumatic fever, school health and public health nursing services. Silent film strips include care of the baby, smallpox, Florence Nightingale and professional nursing, Louis Pasteur and the germ theory, Madame Curie and radium, Robert Koch and tuberculosis, Walter Reed and yellow fever, and tuberculosis.

Any of these visual aids are available to groups upon request made to the local or state health department. Requests stating the date to be used and an alternate date, if possible, and an alternate film subject, should be sent three weeks in advance of the planned showing.

For the convenience of organizations who may wish to use films in their meetings, a catalog of those available from the Department has been prepared. Copies may be obtained from the local health department or the Michigan Department of Health.



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PUBLIC HEALTH CONFERENCE

The 27th Annual Michigan Public Health Conference will be held at the Statler Hotel in Detroit, November 5, 6, and 7, 1947. As in the past, the Conference will be sponsored jointly by the Michigan Department of Health and the Michigan Public Health Association.

Bruce R. Douglas, M.D., Director, Detroit Department of Health, is chairman of the Program Committee. He announces that the plan of the Conference will follow closely that of past meetings, with both general sessions and discussion groups. The opening general session is at 2 o'clock on Wednesday, Nov. 5. Group discussions will be featured on Thursday. The annual meeting of the Michigan Public Health Association will be in the form of a luncheon on Thursday and the Conference dinner is scheduled for that evening. Friday noon will mark the adjournment of the Conference. The Michigan School Health Association will meet on Friday afternoon.

SPECIAL ISSUE OF BULLETIN

The August issue of *Michigan Public Health,* monthly bulletin of the Department, presents highlights of the work of the Department during the fiscal year ended June 30, 1947. Copies of this special issue are available and may be obtained by sending a card or a letter to the Michigan Department of Health, Lansing 4.

VACCINATION BILL VETOED

A bill which would have made vaccination of children prerequisite to their entering school was vetoed by the Governor.

STUDY DEPARTMENT

Among June students and visitors at the department from foreign states were Dr. and Mrs. Segundo Vicinte, Venezuela; Miss Marta Fonticello, Chile; and Miss Tyyne Luoma, Finland.

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What's What

D. J. Jaffar, M.D., Detroit, won the championship in the Wayne County Medical Society's golf tournament, held August 20, 1947. Congratulations, Dr. Jaffar!

* * *

Michigan Medical Service on July 1, 1947, had 932,-356 persons covered by the service certificates. This represented 375,865 contracts.

* * *

Major A. Jackson Day, Detroit, published a paper, "The Treatment Of Injuries To The Tarsal Navicular," in *The Journal Of Bone and Joint Surgery,* April, 1947.

* * *

Wilfrid Haughey, M.D., Battle Creek, spoke before the Grandville Rotary Club in Grand Rapids on Monday, September 22. His subject was "The Evils of Federalized Medicine."

* * *

A reprint of "General Practice in a Large Hospital" by M. H. Miller, M.D., Detroit, originally published in JAMA of May 3, 1947, has been received by the MSMS Executive Office.

* * *

Robert C. Moehlig, M.D., and *H. L. Abbott, M.D.,* Detroit, are authors of an original article, "Carbohydrate Metabolism," which appeared in JAMA of August 30, 1947.

The American Academy of General Practice of Wayne County will sponsor its first refresher postgraduate course for members and other physicians interested, November 19-20, 1947. The courses will be dry clinics offered by the Staff of the Henry Ford Hospital and will be held in the hospital auditorium; the subjects will be those of interest to the general practitioner. There will be no registration fee for Academy members. Registration for non-members will be $10.00 which will include a banquet ticket for the November 20 evening meeting. Anyone interested may write Jos. Montante, M.D., 14202 Fenkell Avenue, Detroit, for program and clinic or hotel reservation.

L. G. Christian, M.D., Lansing, addressed the Williamson Kiwanis Club on September 15. His subject was "Making More General Practitioners for Rural Medical Service."

* * *

Veterans Administration reports that almost 10,000 disabled veterans of World War II have been rehabil-

(Continued on Page 1212)

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(Continued from Page 1210)

itated to date so that they are able to fill technical and skilled jobs within VA hospitals after their release.

* * *

Good medical care is rarely cheap, and cheap medical care is rarely economical.—N. Y. Acad. Med., Report on Medicine in Changing Order, Commonwealth Fund, 1947.

* * *

Clyde H. Chase, M.D., D.Sc., Detroit, has a paper, "A New Eschar Technique for Local Treatment of Burns," published in *Surgery, Gynecology and Obstetrics,* September, 1947.

* * *

Reed M. Nesbit, M.D., Ann Arbor, published a paper, "Some Observations On Transurethral Prostatic Resection," in the *New England Journal of Medicine,* 237:7, August 14, 1947.

* * *

Apologies to Edward J. Panzner, M.D., and R. L. Schorr, M.D., both of Detroit, for typographical errors in the spelling of their names appearing in the Roster, July Number, JMSMS.

* * *

Robert C. Moehlig, M.D., and *H. Lyman Abbott, M.D.,* Detroit, have a paper, "Carbohydrate Metabolism," published in the *Journal of the American Medical Association,* August 30, 1947.

* * *

D. J. Leighthauser, M.D., Chief of Surgery, St. Mary's Hospital, Detroit, spoke at the American Congress of Physical Medicine at the Hotel Radisson, Minneapolis, Minnesota. His topic was "Early Ambulation."

* * *

Michigan's community property income tax law has received the OK of the Federal Internal Revenue Department—latest estimate is that the law will save Michigan taxpayers $25 million this year and $50 million a year hereafter.

* * *

The Obstetrics and Gynecology Index, compiled in the Surgeon General's Library, Washington, D. C., by a staff of professional medical indexers, has been made available by the Washington Institute of Medicine, 1720 M. Street, N. W., Washington 6, D. C.

* * *

N. E. Aronstam, M.D., Detroit, is the author of an article entitled, "Progressive Idiopathic Atrophy of the Skin with Depigmentation," which appeared in the current issue of *Havefuah*—the Palestine Medical Journal, official publication of the Palestine Medical Association.

* * *

"Providing More Health" is the title of an original article by Hugh W. Brenneman, Public Relations Counsel of the Michigan State Medical Society, which appeared in the *Michigan Farmer* of August 16, 1947. The story tells the rural population of Michigan about the Federal Hospital Construction Act and its Michigan counterpart, Public Act No. 299 passed by the Michigan Legislature of 1947.

(Continued on Page 1214)

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Four-week Course in General Surgery, starting October 6, November 3.

Two-week Course in Surgical Anatomy & Clinical Surgery, starting October 20, November 17.

One-week Course in Surgery of Colon and Rectum, starting November 3.

Two-week Course in Surgical Pathology, every two weeks.

MEDICINE—Two-week Course in Gastro-Enterology, starting October 20.

DERMATOLOGY and SYPHILOLOGY—Two-week Course, starting October 20.

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(Continued from Page 1212)

Michigan's census figures have been drastically increased. As of July 1, 1946, 6,049,987 persons lived in Michigan according to a special census report. This is 15.2 per cent above 1940 figures and represents the first time that Michigan's population has been known to top the six million mark.

* * *

The American Association for the Study of Goiter again offers the Van Meter prize award of $300 and two honorable mentions for the best essay submitted concerning original work on problems related to the thyroid gland. Essays must be received by February 1, 1948. For details write T. C. Davison, M.D., Corresponding Secretary, 207 Doctors Building, Atlanta 3, Georgia.

* * *

The American Allergy Fund, an organization for the advancement of medical knowledge, has been founded in Cleveland with Jonathan Forman, M.D., of Columbus, Ohio, as president. The Fund is supported by the annual membership of over 500 physicians with a special interest in allergy, their patients and public spirited individuals and industries.

* * *

The AMA House of Delegates will hold its semi-annual session in Cleveland January 5 and 6, 1948.

In addition, two-day interim meeting of the AMA will be held in Cleveland January 7 and 8, with the program designed particularly for general practitioners.

The regular Annual Session of the AMA will be held in Chicago the week of June 21, 1948.

* * *

Lucy Bartlett of Muskegon has been appointed Executive Secretary of the Muskegon County Medical Society, effective September 1, 1947. This makes three county medical societies in Michigan which employ executive secretaries:

1. Wayne County Medical Society—Else Kolhede.
2. Genesee County Medical Society—Sara Burgess.
3. Muskegon County Medical Society—Lucy Bartlett.

Congratulations, Muskegon County Medical Society!

* * *

Max K. Newman, M.D., Chief of Physical Medicine and Rehabilitation at Grace Hospital, Detroit, and Miss Barbara Jewett, Chief of Occupational Therapy at Wayne University, Detroit, spoke at the American Congress of Physical Medicine at Minneapolis, Minnesota, September 2-6, 1947. Their topic was "A Co-ordinated Program of Physical and Occupational Therapy in a Physical and Rehabilitation Program of a General Hospital."

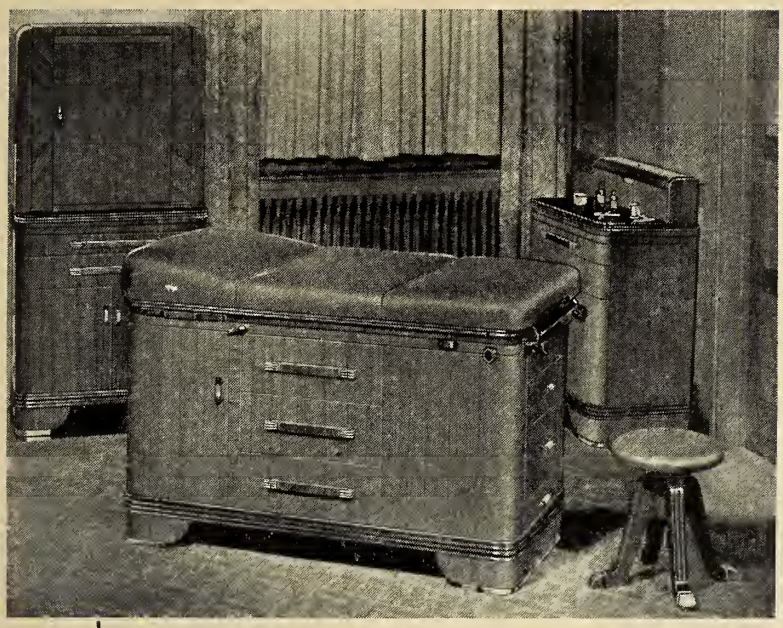
* * *

Robert S. Drews, M.S., M.D., Dr.P.H., of Detroit, was awarded a plaque by the American Literary Guild at the centennial meeting of the American Medical Association as first prize for the manuscript entitled "Crumbling Brest Versus Bungling God?" At the 1946

(Continued on Page 1216)

Say you saw it in the Journal of the Michigan State Medical Society

IMMEDIATE DELIVERY



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meeting of the American Medical Association, the same writer received the Medal of Merit for his original publication, "The Role of the Physician in the Development of Social Philosophy."

* * *

L. Fernald Foster, M.D., Bay City, MSMS Secretary, addressed the Grand Rapids Rotary Club on October 2. His subject was "Medical Care for the American People."

Dr. Foster and Wm. J. Burns, MSMS Executive Secretary, have been invited to speak on the general session program of the 1948 annual meeting of the South Dakota State Medical Association in Sioux Falls on May 24. Their joint subject will be "Medical Economics in a World of Change."

* * *

The Committee on Postgraduate Medical Education, with the approval of the Executive Committee of The Council of the Michigan State Medical Society, is giving credit in postgraduate education to all doctors of medicine for the time they were in military service. According to H. H. Cummings, M.D., Ann Arbor, Chairman of the Committee, "It seems only fair that our doctors of medicine who were active in postgraduate medical education prior to service and since returning from service, should not be penalized but rather honored by having bestowed upon them a certificate of Fellowship or of Associate Fellowship at the hands of the Michigan State Medical Society."

* * *

Parke, Davis & Company Cited for Meritorious Performance.—The Executive Committee of The Council of the Michigan State Medical Society placed on the minutes of its August 29 meeting a vote of high commendation to Parke, Davis & Company for the excellent educational advertisement in the "See Your Doctor" series sponsored by the Detroit firm and being published currently in the leading lay magazines.

The members of the Executive Committee of The Council collectively and individually congratulated Parke, Davis & Company on this outstanding piece of public education, an important, potent development in lay information.

* * *

"Neither Desirable nor Feasible."—The economic approach to this problem of medical and hospital care is not in itself sufficient. It is not even the right approach. It is indeed important to organize a system of prepayment of cost, but to let the matter rest there is a short-sighted procedure. There is more to it than a question of meeting costs conveniently. There is the all-important question of possessing adequate service and facilities in a country to implement the program. These facilities do not now exist in sufficient volume to warrant a universal compulsory health security program, even if it were otherwise desirable. As proposed, however, in the Wagner-Murray-Dingell Bill it is neither desirable nor feasible. . . . This sort of program will exhaust the na-

(Continued on Page 1218)

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(Continued from Page 1216)

tional resources of our country in terms of money, construction time and available teaching staffs, so that it is visionary to talk of a universal compulsory health program for years to come.—"The Future of the Voluntary Hospital" by Bishop Karl J. Alter, D.D., Toledo.

* * *

Members of the Michigan State Medical Society who were honored by election as officers of Sections or as special representatives of the American Medical Association, at the Centennial Session in Atlantic City, 1947, are:

Section on Surgery, General and Abdominal: Delegate—Grover C. Penberthy, M.D., Detroit.

Section on Obstetrics and Gynecology: Delegate—Jean Paul Pratt, M.D., Detroit.

Section on Laryngology, Otology and Rhinology: Secretary—J. M. Robb, M.D., Detroit; Delegate—Burt R. Shurly, M.D., Detroit.

Section on Urology: Chairman—Reed M. Nesbit, M.D., Ann Arbor.

Section on Radiology: Representative to Scientific Exhibit—Samuel Donaldson, M.D., Ann Arbor.

Section on General Practice of Medicine: Secretary—W. B. Harm, M.D., Detroit.

Representative to Board of Governors of the American College of Surgeons—James H. Maxwell, M.D., Ann Arbor.

* * *

Animal Experimentation.—Medical groups in Michigan have scored a victory over ignorance and animosity with the passage of Senate Enrolled Act No. 108, passed by the Michigan Legislature of 1947. Section 1 of the law states, "The public health and welfare depend on the humane use of animals for the diagnosis and treatment of human and animal diseases, the advancement of veterinary, dental, medical and biological sciences, and the testing and diagnosis, improvement and standardization of laboratory specimens, biological products, pharmaceuticals and drugs."

The bill provides for the supervision of animal experimentation by the State Commissioner of Health and an advisory committee composed of representatives of medical, dental, and veterinary schools, the Michigan Board of Registration of Osteopathy, a research laboratory and the State Federated Humane Society. Legislation of this type has been recommended by the Society as a safeguard against antivivisection legislation.—Bulletin of National Society for Medical Research, Chicago, July-August, 1947.

* * *

The AMA-Mutual Broadcasting System weekly radio dramatization, "Stephen Graham, Family Doctor" has just been extended through November 17 but will now be aired each Sunday afternoon at 2:00 p.m. EST. This is a new time of presentation, just announced by the AMA Bureau of Health Education.

"The Story of Surgery" is the title of a new series of radio presentations, available in record (platter) form

(Continued on Page 1220)

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(Continued from Page 1218)

from the American Medical Association. County Medical Societies may procure these, upon application to the Bureau of Health Education, American Medical Association, 535 North Dearborn, Chicago 10, Illinois.

Following are the titles of the records and the physicians interviewed: (1) Progress Since the Middle Ages, Howard W. Haggard, New Haven, Conn.; (2) Making a Surgeon, Malcolm MacEachern, Chicago; (3) Surgery of the Appendix, John O. Bower, Philadelphia; (4) Surgery of the Biliary Tract, Frank H. Lahey, Boston; (5) Abdominal Surgery, Frederick Christopher, Evanston, Ill.; (6) Surgery in Infancy, Willis Potts, Chicago; (7) Surgery in the Chest, Alfred Blalock and William R. Rienhoff, of Baltimore; (8) Neurological and Brain Surgery, Alfred W. Adson, Rochester, Minn.; (9) Surgery and Cancer, Allen Whipple, New York; (10) Plastic Surgery, J. B. Brown, St. Louis; (11) Surgery in the Aged, Arthur W. Allen, Boston; (12) Surgery in the Thyroid Gland, Charles Gordon Heyd, New York; (13) How Do You Know When You Need Surgery? Morris Fishbein, Chicago.

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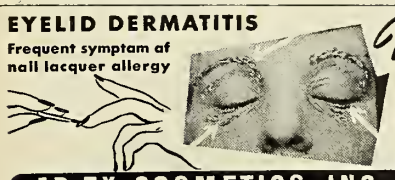

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Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

A DOCTOR IN THE HOUSE. By Henry Pleasant, Jr., M.D. Philadelphia and New York: J. B. Lippincott Co., 1947. Price $3.00.

With a twinkle in his eye, plus plenty of enthusiasm and humor, a small town doctor takes you back behind scenes in the practice of medicine, tracing the astonishing development of medical methods since the turn of the century and providing an entertaining anecdotal account of personalities and cases encountered along the way. "A Doctor in the House" represents an authentic picture of doctoring from the inside out—and a simple explanation of why doctors get gray, prematurely. This is a human and at times amusing story, interestingly told.

OFFICE IMMUNOLOGY INCLUDING ALLERGY. A Guide for the Practitioner. Edited by Marion B. Sulzberger, M.D., and Rudolph Baer, M.D. Chicago: The Year Book Publishers, Inc., 1947. Price $6.50.

This book brings up to date all the advances made during the year in the various fields covered by office procedures of immunology. There are seven authors covering the subjects—diagnostic procedures, prophylactic and therapeutic procedures, immunology of infections, immunologic principles of transfusion reaction—the Rh factor, respiratory allergies and dermatologic immunology. Also included are articles on immunologic management of spider, insect and snake bites.

The book is well prepared, freely indexed, and reference easy.

A MANUAL OF FRACTURES AND DISLOCATIONS. By Barbara Bartlett Stimson, A.B., M.D., Med. Sc.D., F.A.C.S., Assistant Professor of Clinical Orthopedic Surgery, College of Surgeons, Columbia University, New York City; Associate Attending Surgeon, Presbyterian Hospital and Vanderbilt Clinic, New York City. Second Edition, thoroughly revised. Philadelphia; Lea & Febiger, 1947. Price $3.25.

New methods and new knowledge gained from World War II have been used in the revision of this book. Diagrammatic illustrations in the form of line drawings are freely used to illustrate a point. This book is written as a practical guide to be used by practitioners who may not be specialists, but who wish reliable help.

The type is good, easily read, and the book is pocket size.

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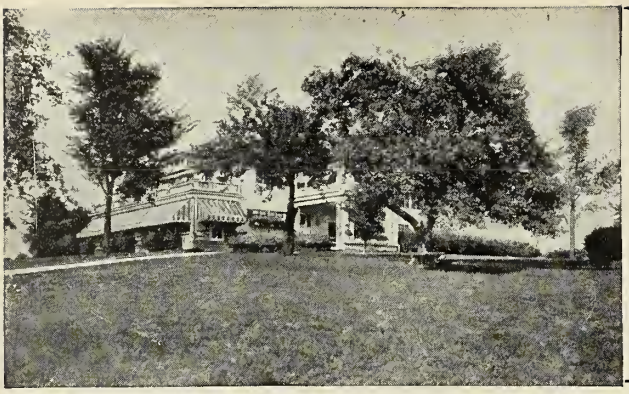

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ROENTGEN INTERPRETATION. By George W. Holmes, M.D., Board of Consultants, Massachusetts General Hospital and Clinical Professor of Roentgenology, Emeritus, Harvard Medical School; and Laurence L. Robbins, M.D., Radiologist-in-Chief to the Massachusetts General Hospital and Associate in Radiology, Harvard Medical School. Seventh Edition, thoroughly revised, with 266 Illustrations. Philadelphia: Lea & Fehiger, 1947. Price $7.00.

New methods of diagnosis and treatment have been introduced. Radiology has especially advanced, requiring new writing. Illustrations are also undergoing revision, many of the roentgenograms being film reproductions rather than prints of the films. This change seems desirable, but such a change would involve reproducing all illustrations and new cuts. The style and diction are good, reading easy and the whole book is authorative. One new author appears, Dr. Robbins. The book will serve well as a handy reference in this field.

SIGNS AND SYMPTOMS, Their Clinical Interpretation. Edited by Cyril Mitchell MacBride, A.B., M.D., F.A.C.P., Assistant Professor of Clinical Medicine, Washington University School of Medicine; Assistant Physician, Barnes Hospital, St. Louis, Mo. 74 illustrations in black and white and color plates. Philadelphia: J. B. Lippincott Company, 1947.

Twenty authors of this book attack the problem of diagnosis in a different manner, being mindful of the idea that taking the history may give more information at times than the physical findings. This is not a text book of diseases, but of signs and symptoms. Pain is the most prominent symptom and manifests itself in various types—deep, superficial, degrees of severity; also as headache which has myriads of manifestations and meanings. Sore tongue and mouth, abdominal pain, backache and back pain, joint pain are also discussed. Fever is another diagnostic symptom which is discussed and analyzed. Fainting, dyspnea, dehydration, cyanosis, edema, cough, heart action, obesity, hemoptysis, and about a dozen others are included.

The symptoms or signs are described, the causation, mechanism and meaning given; without much attention being given to naming a disease. Physical examinations and special tests are outlined, and numerous references are given at the end of each article. A very interesting and useful book.

RISE AND FALL OF MEDICAL INCOMES

(Continued from Page 1192)

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Bibliography

1. Black, Henry C. and Skaggs, Allison E.: The cost of practicing medicine. J. Michigan M. Soc., (Aug.) 1937.
2. Black, Henry C. and Skaggs, Allison E.: A study of incomes and expenses for 1939. J. Michigan M. Soc., (Sept.) 1940.
3. Black, Henry C. and Skaggs, Allison E.: Medical incomes in wartime. J. Michigan M. Soc., (July) 1945.
4. Black, Henry C. and Skaggs, Allison E.: 333 years of medical partnerships. J. Michigan M. Soc., (July) 1947.

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1 For administration from multiple-dose vials, the mixture should be sufficiently fluid to permit easy withdrawal, accurate measurement and easy injection.

2 In all fluid preparations, however, the penicillin has a tendency to settle out. Unless the container has adequate air space and volume to permit resuspension of the settled penicillin by shaking, 24 hour blood levels may not be maintained. Either overdosage or underdosage may result.

3 When injected from individual-dose cartridges, the penicillin in oil and wax suspension should be of slightly thicker consistency. If it is not, and the penicillin settles out, it cannot be resuspended by shaking, because (a) the volume is too small, and (b) the cartridge has no air space.

4 The slightly heavier type of suspension can be easily injected in accurate dosage with a minimum of discomfort to the patient. It is essentially free-flowing at room temperature, and each cartridge contains a full 1 cc. (300,000 unit) dose, which eliminates the need of measuring.

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(Continued on Page 1232)

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(Continued from Page 1230)

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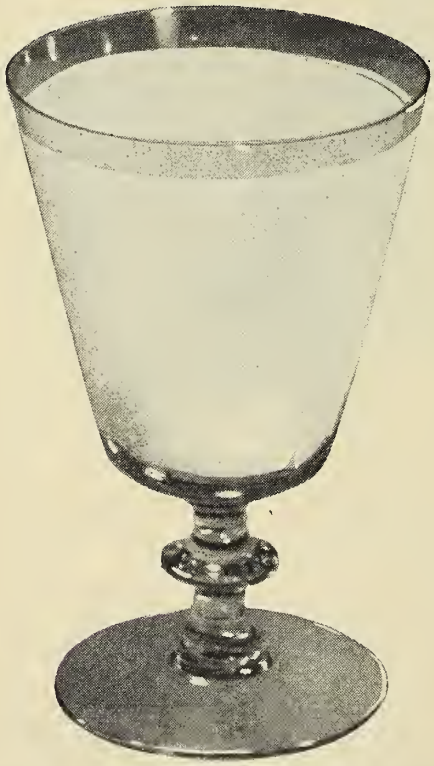

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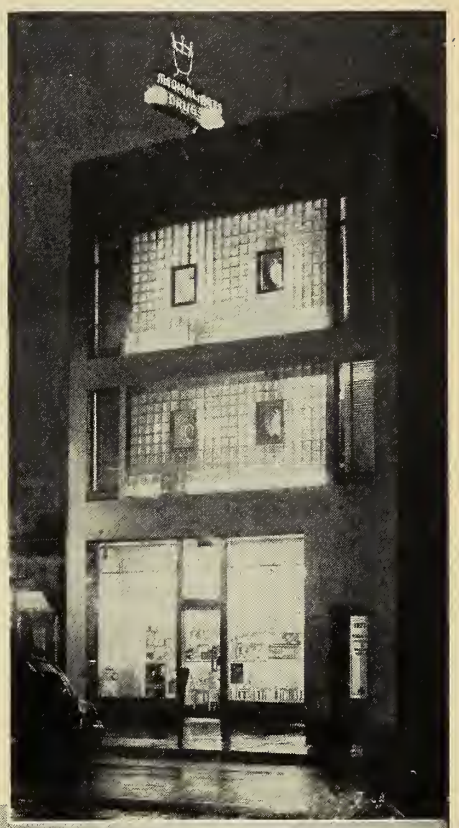

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participate in your 82nd Annual Session. It was a most stimulating meeting."

Frederic E. B. Foley, M.D., Saint Paul, Guest Essayist: "It was a pleasure to attend the meeting and contribute to your program."

S. W. Harrington, M.D., Rochester, Minnesota, Guest Essayist: "I wish to compliment you on your excellent meeting in Grand Rapids. This is the first time that I have attended the Michigan State meeting and it was one of the best and most efficiently managed medical meetings that I have ever attended. I enjoyed having had the opportunity of participating in it."

L. Emmett Holt, Jr., M.D., New York City, Guest Essayist: "I do not know of any medical society whose meetings are better organized for the pleasure and profit of all concerned."

Reynold A. Jensen, M.D., Minneapolis, Guest Essayist: "I want to thank the Michigan State Medical Society for the very warm and cordial welcome I had as one of your guests during the recent Society meeting. It was one of the finest experiences that I have had."

J. R. Lindsay, M.D., Chicago, Guest Essayist: "I enjoyed the visit to the annual session of the Michigan State Medical Society very much."

Clifford B. Lull, M.D., Philadelphia, Guest Essayist: "My entire stay in Grand Rapids was most pleasant and I have never attended a meeting where I felt more at home or had a better time. I can assure you that, as far as I could see, the meeting was a huge success."

C. S. O'Brien, M.D., Iowa City, Guest Essayist: "I thought your Michigan State meeting was a very interesting one. I enjoyed myself in Grand Rapids since I was able to be with some of my old friends. Thank you."

R. V. Platou, M.D., New Orleans, Guest Essayist: "I thoroughly enjoyed meeting with such an enthusiastic group of doctors and participating in the program."

Louis Schwartz, M.D., Washington, D.C., Guest Essayist: "I assure you that I enjoyed talking before the Michigan State Medical Society."

Wendell G. Scott, M.D., St. Louis, Guest Essayist: "The Michigan group is certainly one of the outstanding State organizations in this country; I was amazed by its efficiency and the fine support it receives from the Michigan physicians. It was a pleasure and an honor to have participated in the meeting of the Michigan State Medical Society."

AWARDS TO MSMS FIFTY-YEAR CLUB MEMBERS

Ninety-nine Michigan physicians, who have practiced fifty years or longer, being inducted as Charter Members of the MSMS Fifty-Year Club by President William A. Hyland, M.D., Grand Rapids, and Secretary L. Fernald Foster, M.D., Bay City, in Grand Rapids, September 24.

Clement A. Smith, M.D., Boston, Guest Essayist: "I had a very pleasant time in Grand Rapids and felt that the meeting was, as usual for Michigan, beautifully arranged."

Frank E. Whitacre, M.D., Memphis, Tenn, Guest Speaker: "It was indeed a pleasure to take part in the program of the Michigan State Medical Society, as I felt much at home in that part of the country. I found the meeting one of the most stimulating I have ever attended."

Alexander M. Campbell, M.D., Lansing: "The whole affair was excellently arranged."

Harrison S. Collisi, M.D., Manager Crile V. A. Hospital, Cleveland, Ohio: "Congratulations on a fine meeting. I did enjoy all of it, particularly meeting many of my old friends. Please convey to your officers my reaction regarding the annual session."

B. R. Corbus, M.D., Grand Rapids: "Congratulations on what was the most successful State meeting so far pulled off. I hear words of praise from every side."

Luther W. Day, M.D., Jonesville: "The convention was good and I enjoyed every day of it."

Robert J. Douglas, M.D., Muskegon: "The annual meeting was the best I ever attended."

J. C. Foshee, M.D., Grand Rapids, Chairman of Surgical Section 1946-47: "Please allow me to commend you upon the fine 'show' you put on in Grand Rapids. Dr. Wayne Babcock of Philadelphia told me when he arrived that he had never seen a State program of the caliber of ours. He said, 'This is good enough for any national convention.' Dr. DeBakey told me he had never seen a state medical society program so well organized and so efficient. Dr. Harrington wrote me a similar com-

(Continued on Page 1244)

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Public Relations at the MSMS Annual Session

RADIO PRESENTATIONS

1. Round-table discussion on the subject of "What is the Greatest Problem Facing Medicine Today." Broadcast over radio station WLAV, Grand Rapids and the Michigan Radio Network, Sunday, September 21.

RADIO ROUND TABLE ON "PLANS AND PROJECTS OF THE MEDICAL PROFESSION" Broadcast over Radio Station KLAV, Grand Rapids, September 25 from the MSMS Hospitality Booth, Civic Auditorium, Grand Rapids.

From left to right: E. F. Sladek, M.D., Traverse City, President-Elect; J. S. DeTar, M.D., Milan, Speaker, House of Delegates; L. Fernald Foster, M.D., Bay City, Secretary; P. L. Ledwidge, M.D., Detroit, President; C. E. Umphrey, M.D., Detroit, Councilor, 1st District. With back to camera: Hugh W. Brenneman, Lansing, MSMS Public Relations Counsel.

Participating: E. I. Carr, M.D., President, Michigan Foundation for Medical and Health Education; R. L. Novy, M.D., President, Michigan Medical Service; Hardy A. Kemp, M.D., Dean, Wayne University College of Medicine; L. Fernald Foster, M.D., Secretary, Michigan State Medical Society; and Hugh W. Brenneman, Public Relations Counsel, Michigan State Medical Society.

2. Broadcast by Andrew C. Ivy, M.D., Chicago, Vice President, University of Illinois.

Interviewed by Hugh Brenneman over radio station WLAV, Grand Rapids, Tuesday, September 23.

Dr. Ivy spoke on "The Diagnosis of Jaundice from a Therapeutic Viewpoint." He also related his experiences as Medical Counsel to the Secretary of War and Witness at the Nurnberg war trials in Germany.

3. J. S. DeTar, M.D., Milan, Speaker, House of Delegates, was interviewed on Wednesday, September 24, over radio station WLAV, Grand Rapids, on "Medical Plan for Michigan."

4. Round-table interview on "Plans and Projects of the Medical Profession" over radio station WLAV, Grand Rapids, September 25. Broadcast from Hospitality Booth by Drs. C. E. Umphrey, P. L. Ledwidge, L. Fernald Foster, J. S. DeTar, E. F. Sladek. Hugh Brenneman interviewing.

5. The entire ceremonies of Officers Night, Wednesday, September 24, were broadcast over radio station WLAV, Grand Rapids, and the Michigan Radio Network. This was a one and a half hour broadcast.

6. Hugh W. Brenneman, Lansing, gave a news commentary on the activity of the Michigan State Medica Society Annual Session. Broadcast over radio statio WFUR, Grand Rapids, on Tuesday, September 23 a 4:00 p.m.

Time for these broadcasts was arranged at no ex pense to MSMS, through courtesy of radio statior WLAV, WFUR, Grand Rapids, and the Michigan Radi Network, to which stations and network the thanks c the Michigan State Medical Society are extended.

TALKS GIVEN

1. C. E. Umphrey, M.D., Detroit, Councilor Fir District, spoke before the Optimists Club on Septemb 24 on "MSMS Activity and Plans for the Future Developing the Health Interests of the People."

2. P. L. Ledwidge, M.D., Detroit, President of t Michigan State Medical Society addressed the Exchan Club September 22 on "Background, Purposes a Plans of MSMS."

3. The Medical Assistants Conference, Wednesd September 24, was addressed by: L. Fernald Fost M.D., Secretary, Michigan State Medical Society; J. Miller, M.D., Councilor, Fifth District, Michigan St Medical Society; Jay C. Ketchum, Executive Vice Pr dent, Michigan Medical Service, and Hugh Brennem Public Relations Counsel, Michigan State Medical Socie

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Awards of Merit

At the centennial session of the American Medical Association in Atlantic City, Mead Johnson & Co. sponsored an exhibit of the work of the Physicians' Art Association. Twenty-two Michigan doctors exhibited, and four received the Award of Merit.

The exhibitors were:

Gordon W. Balyeat, Grand Rapids—"Sick Call" (Photography)

Gerhard H. Bauer, Ann Arbor—"Junior College, Texas" (Water Color)

Wm. C. Behan, Lansing—"Rural Life in Cuba" (Oil)

*G. Clair Bishop, Almont—"Bois Blanc Beacon" (Photography)

Morris Braverman, Detroit—"Pensive" (Photography)

Philip W. Brown, Ypsilanti—"My Wife" (Oil)

George H. Cook, Ionia—"On the Ball" (Oil)

Esther H. Dale, Detroit—"Portrait of a Young Lady" (Photography)

R. J. Himmelberger, Lansing—"Cirencester Cathedral" (Photography)

*John L. Isbister, Lansing—"Interrupted" (Photography)

William Kerr, Bay City—"Homemade Trout Rod" (Woodwork)

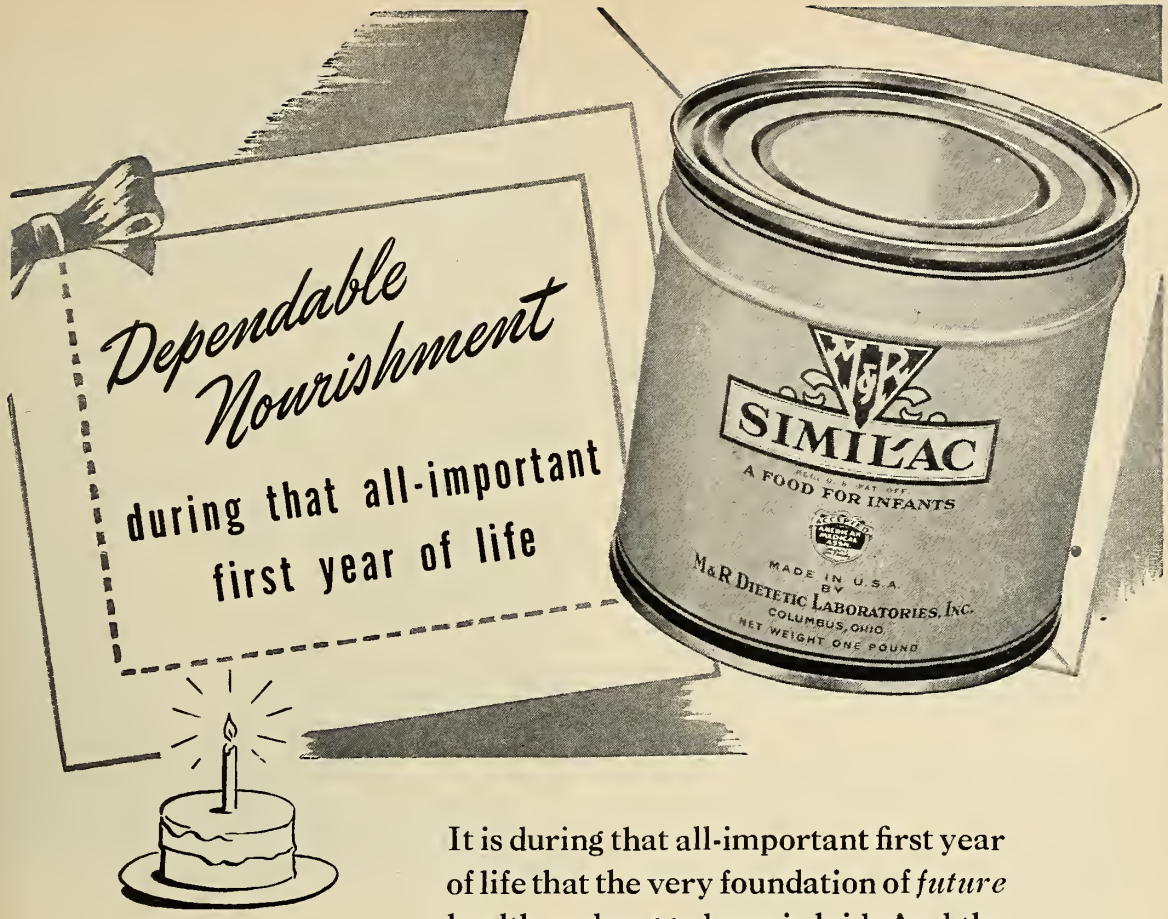
*Oliver W. Lohr, Saginaw—"Four Lambs" (New Mexico) (Photography)

(Continued on Page 1244)

"Four Lambs"—*Lohr*

"Interrupted"—*Isbister*

"Bois Blanc Beacon"—*Bishop*



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AMERICAN COLLEGE OF SURGEONS

The thirty-third convocation of the American College of Surgeons was held in New York the second week of September, and on the final day, September 12, 1947, the following Michigan men were accepted into fellowship:

Robert J. Bannow.....Mount Clemens
John G. Beall .....Traverse City
Leonard L. Cowley .....Detroit
Robert H. Denham, Jr.....Ann Arbor
Kent A. Dewey .....Grand Rapids
Frank Doran .....Grand Rapids
Theodore S. Fandrich .....Detroit
Garth H. Harley .....Detroit
Henry J. Lange ..... Ann Arbor
Walter E. Larson.....Levering
Harold V. Longyear.....Detroit
Clyde S. W. Martin.....Port Huron
Harold E. Mayme.....Saginaw
Nathan D. Munro.....Jackson
Victor E. Nelson .....Detroit
Sheldon R. Newcomer .....Monroe
Eugene H. Quigley .....Dearborn
Bernard L. Rabold .....Detroit
Alven A. Reske .....Dearborn
James A. Rieden.....Detroit
Charles S. Robb .....Grand Rapids
Stanley J. Roman .....Detroit
Emil M. Roth .....Grand Rapids
Milton M. Rozan .....Lansing
Richard C. Schneider .....Ann Arbor
Richard H. Schug .....Detroit
John P. Sheldon .....Sturgis
James D. Sleight .....Battle Creek
Carleton A. Smith .....Pontiac
Russell H. Strange .....Mt. Pleasant
Sylvester W. Trythall .....Detroit
Jacob F. Wenzel .....Detroit
Kenneth A. Wood .....Detroit
Harold W. Woughter .....Flint

FIRST ANNUAL MICHIGAN RURAL HEALTH CONFERENCE

The First Annual Conference on Rural Health for Michigan was held in East Lansing, Michigan, on Michigan State College campus, September 18 and 19, with well over four hundered registered, and many more in attendance. The Conference, with H. B. Zemmer, M.D., of Lapeer as chairman, was sponsored by the Michigan State Medical Society and the following co-sponsors:

Michigan State College
Michigan Department of Public Instruction
Michigan Education Association
Michigan Foundation for Medical and Health Education
Michigan State Grange
Michigan State Dental Society
Michigan Mental Health Commission
Michigan Farm Bureau
Michigan State Social Welfare Commission
Wayne University College of Medicine
Michigan Department of Health
Ingham County Medical Society
Michigan Medical Service
Michigan State Nurses Association
Michigan Tuberculosis Association
Michigan Hospital Service
W. K. Kellogg Foundation
Michigan State Pharmaceutical Association
MSMS Women's Auxiliary
Michigan Hospital Association
Michigan Society for Crippled Children and Disabled Adults
American Cancer Society, Michigan Division
Michigan Crippled Children Commission
Michigan Farmer
Michigan Junior Farm Bureau
Michigan Health Council
Michigan Rural Teachers Association
Children's Fund of Michigan
Michigan Congress of Parents and Teachers

The Conference was a spontaneous success, had many enlightening and enthusiastic talks, one of which is reproduced in this issue, the address of J. S. DeTar, M.D., Milan, Speaker of the House of Delegates of the MSMS. This is a summary, and contains three resolutions adopted by the conference.

The meeting excited extreme interest throughout the state as was evidenced by the attention given it by the press. Three hundred and thirteen newspapers carried feature stories, news stories, editorials and pictures. Various national and state magazines devoted columns to reporting the activities. Radio stations in both rural and urban areas carried the speeches delivered at the Conference and news of the conclusions reached.

The meeting captured the attentive interest and participation of the farmers of Michigan.

The MSMS can well be proud of this venture, but with pride in its accomplishment must go a responsibility for leading a strong effort to carry out the projects recommended by the Conference and to keep on a continuing basis present interest in the development and provid-

(Continued on Page 1248)

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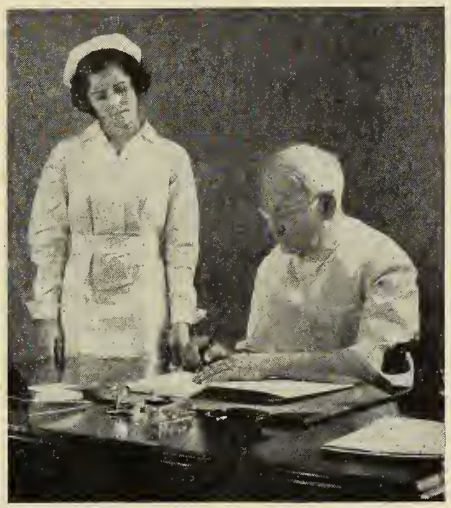

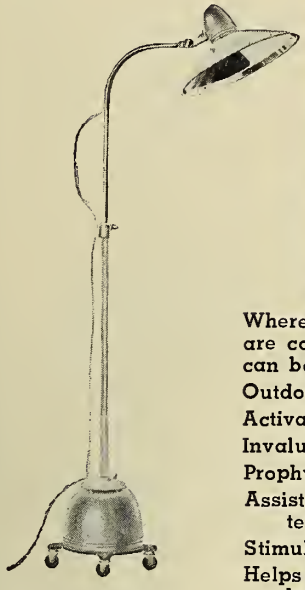

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THE FIRST MICHIGAN RURAL HEALTH CONFERENCE

(Continued from Page 1246)

ing of opportunities for better health in rural communities.

To be specific, the MSMS must:

1. Carry on an educational effort designed to stimulate and inform the people of Michigan regarding the needs which exist and the best means of meeting those needs. In itself this requires two actions:

(a) The determination of needs by proper measurements.

(b) Educational effort through ancillary groups, interested organizations and the various media of communication.

2. Implement the resolutions passed by the Conference among which is the arranging of a Second Rural Health Conference in 1948.

3. Organize a committee to plan a student's medical scholarship fund.

4. Set up a committee to plan and assist in the organization of local health councils in rural areas.

5. Take positive leadership in the development of the Hospital Construction Act passed at the last session of the legislature.

A challenge and an opportunity to the medical profession of Michigan exists as a result of the Rural Health Conference. We must not fail to accept the challenge or grasp the opportunity.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The next written examination (Part I) for all candidates will be held in various cities of the United States and Canada on Friday, February 6, 1948, at 2:00 p.m. Candidates who successfully complete the Part I examination proceed automatically to the Part II examination held later in the year.

A number of changes in Board regulations and requirements were put into effect at the last annual meeting of the Board held in Pittsburgh, Pennsylvania, June 1 to 7, 1947. Among these is the new ruling that the Board does not subscribe to any hospital or medical school rule that certification is to be required for medical appointments in ranks lower than Chief or Senior Staff of hospitals, or Associate Professorships in Schools of Medicine, for the obvious reason that such appointments constitute desirable specialist training. At this meeting the Board also ruled that credit for graduate courses in the basic sciences which involve laboratory and didactic teaching rather than clinical experience or opportunities will be given credit for the time spent up to a maximum period of not more than six months regardless of the duration of the course.

Applications are now being received for the 1948 examinations. Closing date for these applications will be November 1, 1947.

For further information and application blanks, address Paul Titus, M.D., Secretary, 1015 Highland Building, Pittsburgh 6, Pennsylvania.

ORGANIZATION SEMINARS

The first "Organization Seminar" sponsored by the Michigan State Medical Society was held in Berrien County, at the Four Flags Hotel in Niles, Michigan, on November 3. The Presidents and Secretaries of all county Medical Societies in the Fourth Councilor District, were present for a Round Table discussion of local, state, and national problems from 5:30 to 7:00 p.m., which was led by Councilor R. J. Hubbell, M.D., of Kalamazoo. MSMS President P. L. Ledwidge, M.D., Detroit, discussed "Modern Medical Organization," and MSMS Speaker J. S. DeTar, M.D., Milan, presented "Modern Medical Public Relations and Health Education."

This was followed by a dinner meeting of the Berrien County Medical Society at 7:00 p.m. Councilor Hubbell acted as Toastmaster and introduced the following speakers: MSMS President P. L. Ledwidge, M.D., Detroit, who spoke on "Big Problems Face the Medical Profession"; Secretary L. Fernald Foster, M.D., Bay City, "The Biggest Problems are Solved by Good Organization"; MSMS Speaker J. S. DeTar, M.D., Milan, "The Individual Doctor's Responsibility in Medical Public Relations and Health Education"; and Councilor J. D. Miller, M.D., Grand Rapids, who spoke on "The Beneficial Results of Co-ordination of State and County Medical Society Activities."

NEEDLESS DIPHTHERIA DEATHS

No matter how wonderful the discoveries of medical science, they are of no practical value unless applied. Neglect to make full use of preventive measures against diphtheria is proved by the fact that in 1946, there were 121 more deaths from this disease in the United States than in the record year of 1941. The *Journal of the American Medical Association* (Vol. 134, p. 1540) has gathered statistics from nearly a hundred cities of the deaths from diphtheria in 1946. Thirty-one municipalities had a perfect record. In ten more, the mortality was exclusively among nonresidents. Children who live in rural districts where immunization is not thorough are often taken to city hospitals if they become sick. Twenty-seven cities had no diphtheria or typhoid mortality in the year, seven others none of residents. Fourteen New England cities had four times as many diphtheria deaths as in the previous year. Boston had twenty-two, as against one each year in 1942 and 1943. It is clear that infants and preschool children should receive their protective treatments and protective boosters on entering school, and later in life when conditions indicate this is desirable.—*Good Health*, November, 1947.

FOOD SUPPLY

The people of the world are suffering today from a shortage of fats and oils. More than half a century ago, Dr. John Harvey Kellogg made an excellent suggestion, which if carried out would have added greatly to our food resources. It was to plant nut trees on both sides of every highway in the United States. If this had been done, the trees today would be bearing enough fruit to supply huge quantities of protein of the finest quality as well as excellent oils. While much valuable time has been lost, it is not too late to start such a tree-planting program now. This plan fits into the reforestation project on which we have embarked.—*Good Health*, November, 1947.

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Codfish
Coffee
Corn
Crab
Cucumber
Duck
Eggwhite
Eggyolk
Flounder
Gelatin
Ginger
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Herring
Honeydew
Lactalbumin
Lamb
Lettuce
Lima Bean
Lobster
Mackerel
Milk (Cow)
Mushroom
Mustard
Oat
Onion
Orange
Oyster
Pea
Peanut
Pecan
Pepper (Red, Green)
Perch
Pike
Pineapple
Pork
Potato
Prune (Plum)
Pumpkin
Quince Seed
Radish
Rice
Rye
Salmon
Sardine
Scallop
Shrimp
Soy Bean
Spinach
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INCIDENTAL ALLERGENS

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Rabbit Hair
Sheep Wool

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Cladosporium
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Hormodendron
Monilia sitophila
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Doctor Altland Appointed Health Commissioner

J. K. Altland, M.D.

Dr. J. K. Altland became Commissioner of the Michigan Department of Health on September 22. Former Director of the Bureau of Local Health Services of the Department, Dr. Altland was appointed by Governor Kim Sigler to succeed Dr. William DeKleine, State Commissioner since 1944.

Born in White Pigeon, Michigan, Dr. Altland attended the University of Michigan School of Medicine and interned at St. Mary's hospital, Grand Rapids. He practiced in Lowell for eight years and then returned to the University of Michigan receiving his Masters Degree in Public Health in 1938. He spent one year of "internship" in public health administration with the Kellogg Foundation. He served as Director of the Grand Traverse County Health Department for two years. He became Director of the Barry County Health Department in 1940, and held that position for six years, one and a half of which were spent with the United States Coast Guard and the United States Public Health Service. He came to the Michigan Department of Health as Director of the Bureau of Local Health Services in April, 1946.

Dr. Altland has been a member, consecutively, of the Kent County Medical Society, the Grand Traverse-Leelanau-Benzie County Medical Society, member and secretary of the Barry County Medical Society, and member of the Ingham County Medical Society.

Michigan State Board of Registration in Medicine

At the annual meeting held in Lansing, Michigan, Tuesday, October 14, 1947, the Michigan State Board of Registration in Medicine adopted the following regulations with regard to postgraduate education and training in hospitals:

The Michigan State Board of Registration in Medicine may authorize hospitals approved by this Board, offering a satisfactory program of postgraduate education and training, to accept qualified postgraduate students for postgraduate education and supervised training under the direction of the hospital staff and specifically limited to said approved hospital.

Such postgraduate students must be graduates of Class "A" United States Medical Schools and must meet all the educational requirements of the Michigan Basic Science Law and the educational requirements of the Michigan State Board of Registration in Medicine for examination or reciprocal indorsement. Such postgraduate course of study may extend over a three-year period or less.

Before commencing such course of postgraduate education, said student shall apply for registration with the Michigan State Board of Registration in Medicine upon forms to be furnished by said Board. Before such application shall be filed with this Board the acceptance by the hospital of the applicant for postgraduate education and supervised training shall be indorsed thereon. Before commencing such a course of postgraduate education and supervised training, said student shall present to hospital medical director or superintendent proof that he has properly complied with all requirements of the Michigan State Board of Registration in Medicine as herein stated. A certificate authorizing the hospital to receive said students for such training shall be filed with the hospital when the application is approved by this Board.

Registration fee of $10 must accompany said student's application.

Each succeeding year said student shall renew registration and pay fee of $5 for same. Such annual registration must be made between January first and May first of each year. This certificate may be recalled and cancelled by this Board whenever said student has been proven guilty of grossly unprofessional or immoral conduct or has violated any rule of this Board.

Any hospital offering such postgraduate training to any person before the requirements herein prescribed are fulfilled, or after such certificate has been revoked, shall be suspended from the Board's list of hospitals approved for internship training and postgraduate education.

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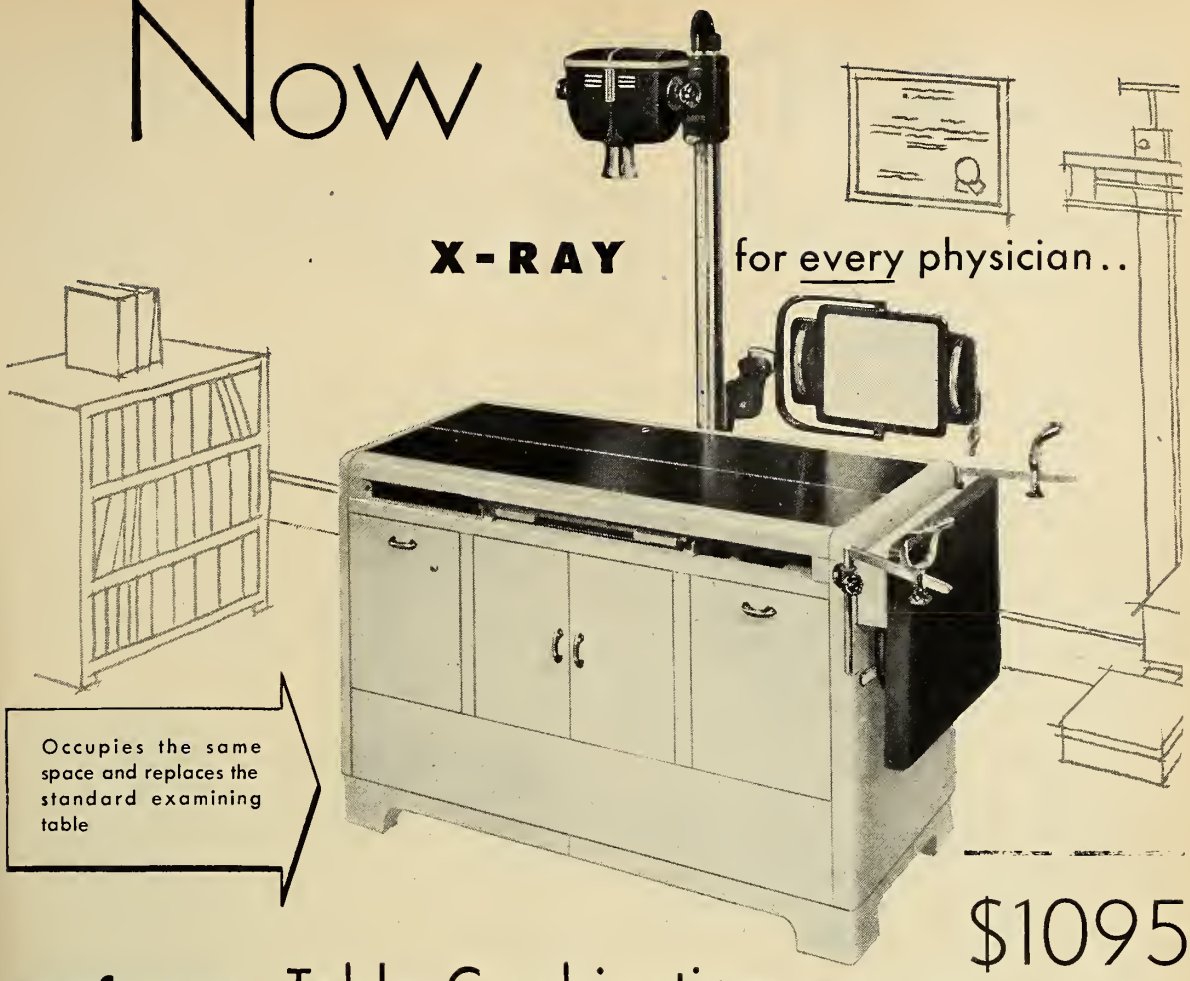

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This brilliantly designed new unit enables the physician to make full use of X-ray techniques *within his own office*. The unit, as pictured, is completely self-contained. It comprises a radiographic unit including the X-ray table, a fluoroscopic unit, a standard examining table, a built-in control unit, and ample storage space for unexposed film. Many design innovations provide for utmost convenience in use.

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Editorial Comment

TERMINATION OF WAR

July 25, 1947, is a day to remember. Following a joint resolution by Congress, the President established July 25, 1947, as the official end of World War II for the purpose of defining periods of eligibility for certain Federal benefits.

The following are the most important effects of this proclamation:

Readjustment Allowance

To be eligible for the Readjustment Allowance under the provisions of the Servicemen's Readjustment Act of 1944, the veterans "must have served in the active military or naval service of the United States (or its Allies, according to Public Law 268) at any time after September 16, 1940, and prior to the termination of the war." The act further provides that payment will be made for unemployment which "occurs not later than two years after discharge or release or the termination of the war, whichever is the later date" and that "no Readjustment Allowance shall be payable for any week commencing more than five years after the termination of hostilities in the present war."

This means that since the war terminated on July 25, 1947, eligible veterans discharged on or before that date have until July 25, 1949, to receive the Readjustment Allowance. Eligible personnel still in service will have until two years of their discharge to apply for the Readjustment Allowance but no payment will be made for any week of unemployment beginning after July 25, 1952.

Education

Education and training benefits under the GI Bill provide, "that such course shall be initiated not later than four years after either the date of discharge or the termination of the present war, whichever is later: provided further that no such education or training shall be afforded beyond nine years after the termination of the present war." Public Law 16, as amended, imposes the same time limitation for the completion of vocational rehabilitation.

This means that education or training under the GI Bill or vocational rehabilitation under Public Law 16, as amended, must be completed on July 25, 1956. Under Public Law 346, education or training must be begun by July 25, 1951, but may be begun at any time under Public Law 16.

Loans

The Servicemen's Readjustment Act states that: "any loan made by such veteran within ten years after the termination of the war . . . is automatically guaranteed by the Government . . ."

The termination of the war means that the 10-year period within which veterans must apply for a loan guarantee under Public Law 346 will expire on July 25, 1957.—Editorial, *Connecticut State Medical Journal,* September, 1947.

STOP—LOOK—LISTEN

STOP telling the patient there is nothing wrong with him but nerves—Don't say: Go home and forget it.

LOOK for the facts as the patient sees them.

LISTEN attentively to patient's story.

* * *

Few people are hurt by overwork. More are injured by what they do and by what they think when they are not working.

* * *

The patient who is always tired is more liable to be suffering from emotional fatigue than from anemia or avitaminosis.

* * *

The most valuable thing in the treatment of a nervous, emotionally disturbed patient is to have security—not to the point of too great dependency.

* * *

You can't treat the emotional problems in your own family.

SOCIALIZED MEDICINE

"Nothing was ever conceived or devised which would more effectively reduce the medical profession to dependence on the government and tie state and local agencies to the wheels of the federal government. It is a threat which deserves far more public attention than it has yet been receiving."—Raymond Moley, *Chicago Journal of Commerce,* July 9, 1947.

The JOURNAL

of the Michigan State Medical Society

Issued Monthly Under the Direction of the Council

VOLUME 46 NOVEMBER, 1947 NUMBER 11

Michigan Rural Health Conference

By J. S. DeTar, M.D.
Milan, Michigan

THE UNDERLYING objective in calling together so many leaders in farm and medical circles into this rural health conference, was to afford an opportunity for the consumers of medical service, the rural people, and the producers of medical service, the doctors, nurses, and hospitals, to express freely their views and their problems; to discuss together the possible solutions of those problems, and to chart, if possible, a course of action which may aid in their solution.

Several hundred people have gathered from all over the State of Michigan here in East Lansing. For two days we have listened to eminent authorities describe to us the nature of the problem of supplying better medical service to our rural people. We have discussed at length the facts presented, and we have reached some conclusions.

To say merely that a conference such as we have held during the past two days is beneficial is an understatement. It cannot help being of value. The mere discussion of the problems of rural health, the mere bringing out into the open of divergent opinions is bound to be provocative of some good. However, too many conferences on too many subjects in too many places result in words, just words, with no action.

This is our first Michigan rural health conference. There must be more to follow. We cannot solve all our problems in a year. We have been seeking facts, and attempting to determine the character of the needs. Studies already under way will continue. Of the many factors about which we have heard during the conference, I should like to cite five which impress me as being particularly important.

First.—The Commission on Health Care of the Michigan State Medical Society described by Dr. Ralph Pino of Detroit will continue its work in attempting to determine the segment of medical practice which is being serviced by each of the medical associates groups: nurses, laboratory technicians, physical therapists, medical photographers, psychologists, optometrists, and a host of others. This Commission is doing investigatory work, ground work. The recommendations of the Commission at the conclusion of its work may have profound and far-reaching effects on rural medical service, on the co-ordination of all types of medical services, with resultant improvement in quality and distribution of service in rural areas.

Second.—The investigation of the exact medical needs of rural areas in Michigan, described to us by Dr. Charles P. Loomis, and now being carried on under the supervision of the Department of Sociology of Michigan State College, will take time. Much work remains to be done. This work may take two or three years to complete. The findings may well surprise us. They may alter our course of action in our effort to improve rural health care.

Third.—The construction of small hospitals in rural areas, under the Hospital Construction Act,

Address given at the Rural Health Conference held at East Lansing, September 18, 19, 1947.

and the establishment of health centers, as described to us by Dr. Emory W. Morris of Battle Creek, may alter the pattern of rural medical care markedly in the next five years.

Fourth.—The extension of hospital insurance and medical and surgical insurance into the rural areas, as described to us by Dr. Robert L. Novy of Detroit, may surprise even the proponents of the voluntary system of prepaid insurance, and confound its critics.

Fifth.—The recognition by the AMA, by the MSMS, and by the medical schools of the need for more general practitioners, and better trained general practitioners, and the growth of the newly formed American Academy of General Practice, a program of general practice, are certain to influence medical students to train for general practice where the field is open, rather than for specialties in the large cities where the field is more crowded. Thus, rural medical care will benefit.

The point I am making is simply this: with all these investigations to determine need, with all this hospital construction, with all this emphasis on the need for general practitioners and rural practitioners, the whole problem is certain to be in a state of flux, of change, for the next few years.

This rural health conference cannot determine and outline a policy ten years ahead, or even for the next three years. But we can provide for the continuation of the good work started here. This brings me to the first plank in the platform for action: Namely, *that we here today do authorize the sponsor and co-sponsors of this conference to set up a permanent committee to arrange for a second rural health conference,* to be held in 1948.

Second is the question of medical scholarships for rural students. Dr. W. H. Huron reported Dr. A. C. Furstenberg's opinion in favor. This idea is not new, but it is not in operation in Michigan. The theory underlying the provision of scholarships to rural youth for education in medical schools is that rural students are more likely to return to rural areas, that their background has equipped them to enjoy rural living, and that at least a fair percentage will remain in rural areas. Other states are far in the lead of Michigan in foreseeing the benefits of scholarships for rural medical students.

Virginia has had four scholarships for many years. The legislature this year increased the number to twenty. The recipients agree to practice in rural areas on completion of internship.

In Illinois, the medical society has proposed to the legislature that a fund of $50,000 per year for ten years be set aside for scholarships to aid in relieving the rural physician shortage. Their plan includes loans to students from rural families, and the loans must be repaid. It also includes the agreement that each student will practice in a community of less than 10,000 population until the loan is repaid.

Alabama has over 500 premedical students competing for the $400 a year scholarship awarded in each of the sixty-five counties of the state.

The doctors of Indiana are financing six $500 a year scholarships.

In Kentucky, the doctors launched a campaign last fall for $100,000 for a loan fund, and by May 8 of this year the fund had reached $150,000.

Mississippi has had the most ambitious plan of all. Last year the legislature appropriated $300,000 for such scholarships. The people of Mississippi KNEW that scholarships brought doctors into rural areas, because they had already completed an experimential trial which brought twenty-three young doctors back to the state after training in other states. Mississippi now has eighty-six students attending fifteen medical schools, all on scholarship loans, with committments to return to rural Mississippi to practice. Their loans will become paid automatically by five years of rural practice. Applications for these scholarships in Mississippi came from 120 towns in seventy-four of the eighty-two counties, over 250 of them.

South Carolina has fourteen scholarships, and Virginia has twenty.

It certainly seems that the great State of Michigan, leader in voluntary health insurance, leader in so many fields, should not lag in the provision of better facilities to her rural areas. The need is here, the money is here. All that is needed is a program for action. And we, in this room, can initiate such action.

In Michigan we have an organization called the Michigan Foundation for Medical and Health Education. It was organized by the doctors of Michigan, who have given $116,000 to start a fund which we hope will grow to $5,000,000. The Foundation could well administer the details of scholarship awards, or at least could provide a focal point for the start of a campaign. We here in this room can decide—today—on a policy which

will lead to the provision of scholarships for medical education of boys and girls of our rural areas, and for scholarships to enable medical students to finish training—such scholarships to be contingent upon rural practice after internship. The experimental period is passed. Other states have used the method. It has proved successful. It simply remains for those who are most interested in rural health to take the initiative. Therefore, I propose as the second plank in the platform of action *that this conference authorize the sponsor and the co-sponsors of this conference to set up a committee to investigate, to plan and organize a students' medical scholarship fund.*

Third is the extension of rural enrollment in hospital and medical prepaid insurance plans. We have heard much of the need for reduction in the costs of medical care for rural people, and at the same time, much of the need for improvement in the quality and quantity of medical care. Without application of the insurance principle of spreading the high costs among large numbers of people, this would be very difficult.

A good start has been made. Michigan Medical Service now insures 927,000 people in Michigan. Michigan Hospital Service now insures 1,221,000 people in Michigan. These are large numbers. However, we heard Dr. Novy tell us this morning, rural enrollment has lagged. Only 29,000 of the million are enrolled through their Granges and Farm Bureaus. This does not mean that rural people cannot and will not expend funds for that insurance, but it means that proper and adequate education and facilities have not been provided for rural enrollment. Present indications, however, are encouraging. The Farm Bureau is backing an effort to enroll the Co-Ops, with payment of subscription fees by deduction from produce checks. During March of this year, Farm Bureau enrollment accounted for 23 per cent of the hospital insurance written, and 17 per cent of the surgical insurance written in Michigan by the Blue Cross. Progress this year is good, but other states have done much better. In the State of Iowa, for example, County Health Councils have been set up for the express purpose of organizing groups which will be eligible for Blue Cross Membership. In that state, which is 55 per cent rural, sixty-nine counties have been organized, and 25 per cent of the 400,000 subscribers to Blue Cross are in rural areas. If it can be done in Iowa, it can be done in Michigan.

I believe it can be done by the sponsor and co-sponsors of this conference. Rural people, more than any other group of the population, are individualists who prefer to run their own business in preference to turning it over to the government to run for them. It is my belief that tens of thousands of Michigan rural people will express preference for voluntary medical and hospital insurance of the Blue Cross type when they learn that it is available to them, and that these same people will oppose a government-dominated politically controlled compulsory insurance plan such as that proposed by Wagner, Murray and Dingell. And, incidentally, not all communities are asking for Federal funds for their hospital construction, not wishing government dictation. Durand, for example, is planning a $200,000 addition without Federal funds. The Blue Cross organizations of this state are cognizant of the desirability and necessity of increasing their rural enrollment.

The Blue Cross organizations are willing to go into any community in the state which is organized for the purpose, and to conduct a community membership drive which will enable every person under sixty-five in the community to have hospital and surgical insurance. Next month, October, will see the first of these rural enrollment campaigns in action, in the City of St. Johns. Any village or any city in the state may follow suit, if the public, the doctors, and the hospitals in the area will back the campaign. And it isn't so difficult.

There exists in almost every community in the state some type of health committee or organization devoted to better health of the people. In some communities there are many overlapping committees. The formation of local health councils consisting of representatives of all interested organizations, and co-ordinated by a State Health Council, could do much to further the education of rural people on the advantages of prepaid medical and hospital insurance. Such a state-wide organization could co-ordinate and standardize and assist in the solving of health problems the state over. We should be far out ahead of the rank and file. We can be. This leads me to third plank in the platform of action. I propose that *this conference authorize the sponsor and the co-sponsors to set up a committee to plan and assist in the organization of local health councils in rural areas,* under the leadership of the Michigan Health Council, for the purpose of assisting, co-ordinating and imple-

(Continued on next page)

Widespread Metastatic Carcinoma

Case Study

By Louis L. Kazdan, M.S., M.D.
Detroit, Michigan

THIS CASE illustrates the clinical course of widespread metastatic carcinoma in a patient receiving diethylstilbestrol. Interest in this case lies in the fact that the primary source of this malignancy was unknown but because of the favorable response to diethylstilbestrol, along with circumstantial evidence on roentgenography, it is presumed that the prostate gland was the offending source.

Mr. E.S., a sixty-nine-year-old white man was admitted to the medical service of the Grace Hospital in Detroit on December 3, 1946, complaining of severe pain between the shoulders, left chest and right lower abdomen accompanied by a marked loss of weight. He indicated that the above symptoms became gradually apparent several months previously, but prior to that time he considered his general health to be quite good.

Upon hospitalization, the patient appeared chronically ill and markedly emaciated, his weight then being 95 pounds. Temperature, pulse and respiration were 97.6°, 120 and 20, respectively. Marked pallor of the skin was evident. No lymphadenopathy was detected. The tones of his already tachycardiac heart were of poor quality, and bilateral basal râles were audible within the lungs. Examination of the abdomen revealed some gaseous distension and considerable tenderness in the right lower quadrant. The liver edge was palpated two fingerbreadths beneath the right costal margin. No other abdominal masses could be detected. Rectal palpation of the prostate gland revealed no abnormalities, the lobes being small, fibrotic and symmetrical.

A gastrointestinal series was taken to rule out this system as the possible primary source of malignancy. It was then that incidental "osteoplastic metastatic (? prostatic) lesions were observed scattered throughout the skeletal structures of the chest." The gastrointestinal tract itself was negative.

Laboratory studies on admission revealed the following results: hemoglobin 7.5 gm. or 45 per cent, red blood cells 2,130,000, white blood cells 4,100, with a differential count of polymorphonuclears 57 per cent (filamented 54 per cent, nonfilamented 3 per cent), eosinophiles 11 per cent, lymphocytes 30 per cent, monocytes 2 per cent. Marked hypochromia was apparent. A 1+ albumin was the only positive urinary finding. In view of the hopeless widespread metastatic lesions and severe malnutrition, further laboratory studies were not undertaken. The patient was given 500 c.c. of whole blood and narcotized with 75 mg. of demerol to help relieve his immediate discomfort, and was discharged to continue with home care. He was prescribed to take liver, iron and vitamin B complex along with an empirical dosage of 2 mg. of diethylstilbestrol daily.

The patient was re-examined on March 5, 1947, and the skeletal changes previously described still persisted. "No demonstrable neoplastic infiltrations were present in the lung fields." The hematological picture was markedly improved and the following results were reported: hemoglobin 12 gm. or 72 per cent, red blood cells 3,580,000, white blood cells 8,100, with a differential count of polymorphonuclears 80 per cent (filamented 78 per cent, nonfilamented 2 per cent), eosinophiles 1 per cent, lymphocytes 14 per cent, monocytes 4 per cent, basophiles 1 per cent. The red blood cells appeared normal.

By April 21, 1947, the patient's weight had risen to 134 pounds, and the symptoms of which he had severely complained had long since totally disappeared.

MSMS

MICHIGAN RURAL HEALTH CONFERENCE

(Continued from preceding page)

menting all programs contributing to the health of the people.

These three propositions, then, I leave with you as a plan of action—a platform which is small but definite, composed of only three planks, but still a beginning. To recapitulate, I propose that we authorize the sponsor and co-sponsors of this conference to do three things:

1. Set up a committee to arrange for a second rural health conference in 1948, and to assume the responsibility of implementing the resolutions already passed by this conference.

2. Set up a committee to investigate, plan and organize a students' medical scholarship fund.

3. Set up a committee to plan and assist in the organization of local health councils in rural areas.

If this conference can close with a program, a specific program, a program which will lead to action and not mere words, a program which will carry the spirit of these meetings into the realm of constructive activity, then we shall have accomplished something—something for the health of the people of rural Michigan.

(The conference adopted the three proposals. EDITOR.)

Prolapse of the Umbilical Cord

By Louis E. Doerr, Jr., M.D.
Detroit, Michigan

PROLAPSE of the umbilical cord is a relatively infrequent complication of parturition. It is of great significance, however, because of the accompanying high fetal mortality rate, which varies from 40 to 80 per cent.[7] The incidence of prolapse of the umbilical cord has been reported by Bourgeois[1] as one in 237 deliveries. Kurzrock[4] reports one in 169. Mengert and Longwell[6] report one in 164. Peterson and Miller[7] feel that the incidence is about one in 400 deliveries.

Due to the variation in incidence as reported in the literature and also to the fact that the writer has had two cases of prolapsed cord occur within three months which were terminated successfully, we decided to review the cases of prolapse of the umbilical cord at Mount Carmel Mercy Hospital since its inception in September, 1939, to January 1, 1947. During this eight-year period there were twenty-five cases of prolapse of the umbilical cord in 25,461 deliveries, or a ratio of 1:1,018. This finding is at wide variance with all reports encountered in the recent literature.

The cause of prolapse of the umbilical cord according to Titus[9] is anything which prevents the presenting part from entering the pelvis and filling it. Others who have discussed the subject are in apparent agreement. The subject presents a broad field of investigation since myriad causes may be listed which influence adaptation of the presenting part to the pelvis. In our review of the cases at Mt. Carmel Mercy Hospital we paid special attention to presentation, parity, pelvic disproportion, and period of gestation.

Presentation

We found approximately the same distribution as reported by other writers. In our series there were: vertex, fifteen cases; breech, eight cases; transverse with shoulder presenting, two cases. Strangely enough, there were no cases of prolapsed cord in twin pregnancies.

Parity

There were ten primiparas in our group. Because of the small number of cases in our review, no definite conclusions can be drawn regarding the significance of multiparity as an etiological factor in the production of prolapsed cord. Mengert and Longwell,[6] however, stress the dangers of operative delivery in primiparas. They found in their investigation that the fetal mortality rate in primiparas was almost twice that in multiparas, largely due to operative procedures used in delivery.

Pelvic Disproportion

Although pelvic disproportion is considered to be a primary factor in the production of prolapsed cord, we found but two cases of pelvic disproportion in our group. The first was a case of hydrocephalus in which the cord prolapsed when a podalic version was done after attempts to deliver by forceps had failed. The other was a borderline cephalopelvic disproportion undergoing a trial of labor. The membranes ruptured spontaneously with 2 to 3 centimeters dilatation of the cervix and the cord prolapsed. Cesarean section was performed immediately, and a living baby was delivered.

Period of Gestation

Prematurity has been listed as one of the causal factors in the production of prolapsed cord due to the resulting relative disproportion of the presenting part to the pelvic inlet, and due to the preponderance of breech presentations in this group. In our series, twenty-one were full term pregnancies. Of the remaining, two were eight month pregnancies and the other two were less than six months.

Our fetal salvage compares favorably with other series published. In our group of cases, fourteen babies were delivered alive, or a survival rate of 56 per cent. In analyzing our survival rate closely it was noted that the degree of cervical dilatation at the time of the umbilical prolapse was in direct correlation with the fetal mortality.

TABLE I. FETAL SURVIVAL

Status of Cervix	*Living Babies*	*Dead Babies*
1. Cervix fully dilated or dilatable	10	4
2. Incomplete dilatation of cervix	4	7

From our findings in Table I, it is an obvious conclusion that time and ease of delivery play a significant role in fetal survival. Further analysis

of unsuccessful treatment in cases in Group 1 above is explained in Table II.

TABLE II. CERVIX FULLY DILATED OR DILATABLE WITH DEAD BABIES.

Treatment	*Condition of Baby Prior to Treatment*
1. Immediate low forceps delivery after membranes ruptured and cord prolapsed.	Cord pulsating weakly when treatment started. Signs of fetal distress prior to accident.
2. Immediate breech extraction.	Baby in poor condition before treatment started.
3. Low forceps delivery.	Fetal heart irregular before delivery attempted.
4. Version and extraction. Craniotomy.	Condition good. Baby was hydrocephalic. Attempted forceps delivery failed. Prolapse occurred during version.

Table III summarizes briefly the treatment used and the results obtained in Group 2 of Table I.

TABLE III.

Treatment	*Remarks*
1. Manual dilatation of cervix with breech extraction.	Pulsations of cord ceased after prolapse and heart tones not heard. Baby resuscitated. See Case 1.
2. Cesarean section. Cervix 2-3 cm. dilated.	Baby in good condition prior to treatment. Cried lustily on delivery.
3. Conversion of shoulder presentation to breech with immediate extraction. Cord replaced before manipulation.	Baby in fair condition and resuscitated easily.
4. Breech extraction following Dührssen's incisions.	Baby in poor condition prior to treatment and died during delivery.
5. Conversion of shoulder to breech with immediate extraction.	Baby in good condition and survived.
6. No treatment. Labor and delivery allowed to progress normally.	Cord collapsed and pulseless on admission. No fetal heart sounds. Stillborn.
7. Midforceps delivery after manual dilatation of cervix.	Baby poor. Heart tones irregular. Died during delivery.
8. No treatment.	No heart tones on admission.
9. No treatment.	Baby markedly premature. Stillborn.
10. Low forceps delivery after attempted replacement and bagging.	Baby poor. Stillborn.
11. No treatment.	Baby dead on admission.

Case Histories

Case 1.—Mrs. W. M., primagravida, aged twenty-three, had her last menstrual period March 17, 1946, the estimated date of confinement was December 23, 1946. Her prenatal course was entirely uneventful. Pelvimetry revealed a gynecoid pelvis with no apparent disproportion. When last seen prenatally, a diagnosis of breech was made—position S.R.P.

Mrs. M. went into labor spontaneously and prematurely on December 8, 1946, in the morning and had irregular contractions all that day. She was admitted to Mt. Carmel Mercy Hospital on the evening of December 8, with contractions occurring every eight minutes and lasting about thirty seconds. A rectal examination on admission revealed only a fingertip dilatation with the breech at minus two station. Contractions continued at eight-minute intervals throughout the night, and in the morning the cervix was 2 to 3 centimeters dilated with the presenting part at station zero. The fetal heart tones were of good quality and heard in the right lower quadrant. The rate was 140 a minute. A few hours later dilatation had progressed to 5 centimeters, and the patient was given 100 mg. demerol hydrochloride and 1/150 gr. scopolamine intramuscularly for analgesia. Analgesia was satisfactory. At 9:40 a. m. the membranes ruptured spontaneously at the height of a contraction and the umbilical cord prolapsed and protruded from the vagina. A pelvic examination was done immediately and the cervix was found to be about six centimeters dilated and soft. No pulsations were felt in the cord and the fetal heart tones were not heard. No attempt was made to replace the cord, and the patient was transferred to the delivery room for immediate delivery in an effort to secure a live baby, since the heart tones had been strong and regular prior to the accident. The patient was placed in deep Trendelenburg and lithotomy positions and given deep ether anesthesia. As soon as satisfactory anesthesia was obtained, a manual dilatation of the cervix was done and the baby delivered by breech extraction at 9:49 a. m., just nine minutes after the cord prolapsed. The baby, a 7 pound 2 ounce girl was resuscitated, and survived. The patient's postpartum course was normal except for a rise in temperature to 100.6° on the third to fifth postpartum days with a foul lochia. This was controlled with sulfadiazine and the symptoms subsided on the sixth postpartum day. The patient and baby were discharged on the ninth postpartum day.

Case 2 (not included in the above series).—Mrs. G. H., primagravida, aged twenty, had her last menstrual period April 11, 1946, the estimated date of confinement was January 17, 1947. Her prenatal course was normal and without incident. Pelvimetry was normal, and a diagnosis of gynecoid pelvis was made. At our last prenatal examination a diagnosis of O.R.P. was made, with the fetal heart tones being heard best in the lower right quadrant toward the flank.

Mrs. H. went into labor spontaneously the morning of January 25, 1947, and progressed normally, complete dilatation being attained at 1:30 a. m., January 26. Twenty minutes later the membranes ruptured spontaneously. A routine check of the fetal heart tones revealed a marked irregularity in rate with each contraction of the uterus. A pelvic examination was done immediately and a loop of umbilical cord was found at the side of the head. Pulsations were faint. The patient was delivered at once under deep ether anesthesia with low forceps, taking great care not to compress the loop of cord between the forceps blades and the head. The infant was resuscitated after fifteen minutes of artificial respiration, and survived.

This case, while not included in the original series,

has been inserted because it presents a situation frequently missed, that of occult prolapse of the umbilical cord. If this condition is to be detected, it is imperative that fetal heart tones be checked regularly and frequently during labor, and, especially, immediately following rupture of the membranes.

Conclusions and Recommendations

1. Early recognition of prolapse of the umbilical cord, particularly the occult variety, offers the only chance for survival of the infant. This may best be accomplished by regular and frequent check of the fetal heart tones during labor, and especially following rupture of the membranes, and with prompt pelvic examination whenever signs of fetal distress appear.

2. Successful termination should be anticipated with complete, or near complete, dilatation of the cervix by appropriate operative intervention. The procedure selected should be done promptly but without undue haste, remembering that operative intervention itself can be traumatizing to the mother, as well as to the baby.

3. Prompt recognition with the more frequent recourse to cesarean section in patients with incomplete dilatation of the cervix should improve our end results in this group. On recognition of a prolapsed cord, the patient should be placed on a delivery table in a combination lithotomy and Trendelenberg position and be put under deep ether anesthesia. A sterile pelvic examination should be done at once for diagnosis and to lift the presenting part of the pelvis, thereby relieving the pressure on the prolapsed cord. An effort to replace the cord manually is always in order. Fetal heart tones are checked constantly. The examiner should keep the presenting part elevated until a course of action has been decided upon and the patient is anesthetized. In a primipara, or in multipara with less than 5 centimeters dilatation and recovery of fetal heart tones, cesarean section is the preferred course of treatment. In a multipara with more than 5 centimeters dilatations it may be possible to obtain full dilatation by manual means or by use of a dilating bag. A bag precludes successful replacement of the cord.

If the infant shows signs of severe distress which do not improve with elevation of the presenting part, or has already died, no operative procedure should be considered.

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Prostatic Surgery

A Review of 100 Consecutive Cases

By R. J. Hubbell, M.D. and
R. N. Kilgore, M.D.
Kalamazoo, Michigan

R. J. Hubbell

THE PURPOSE of this article is to present a picture of prostatic surgery as a result of a review of 100 consecutive cases recently operated upon by us. It is a picture of contrast, to be sure, when compared to the type of surgery and mortality rate of prostatectomies fifteen years ago, and represents a challenge to effect a similar improvement in the cure of chronic infections of the prostate.

Diagnosis

Rectal palpation with the examining finger is the simplest and best method of diagnosing the enlarged prostate. It is true that many fine points in the contour and actual size of the gland can be further elicited by cystoscopy, urethrography and cystography, but in the majority of cases this is unnecessary instrumentation. Occasionally, lower urinary tract obstruction is present with a normal sized prostate to palpation. In these cases, after urethral stricture has been excluded, and a neurogenic bladder ruled out by cystometry, cystoscopy may be valuable, but it is probably better to be prepared to perform a resection at the time of the inspection of the gland transurethrally.

Diagnosis of malignancy of the prostate is, of course, simple in many cases, if it is at all advanced, because of the "stony hardness" of the gland, but firm nodules in the gland are puzzling and may represent an early malignancy. Confusing issues here are chronic infection, prostatic calculi, and recently such a nodule proved, on routine section, to be an infectious granuloma of undetermined cause, and included a microscopic focus of adenocarcinoma.

It seems logical to assume that if early carcinoma of the prostate, as in other organs, is to be cured by surgery, it must be resected widely. Therefore, perineal exposure, with biopsy of the suspected

nodule, should be done and if found positive, radical removal should be carried out. Three cases in this series were thus exposed, two proving to be malignant, and in the two instances radical perineal prostatectomies were performed. In the third case, no malignancy was found, and only a simple perineal prostatectomy was done. The over-all evidence of cancer in this group is 17 per cent.

Preoperative Care

An operation is advised mainly for the following findings: (1) residual urine of 3 ounces or more, (2) marked dysuria, (3) suspected early carcinoma, even in the absence of any urinary symptoms.

These criteria in the main have been followed, but they may be subject to modification in individual instances. Thus, dysuria may be so marked with a residual urine of less than 3 ounces that an operation may be indicated. Residual urine of more than 3 ounces that is persistent jeopardizes the integrity of the upper urinary tract and demands investigation. Residual urine or, indeed, urinary discomfort should not be a requirement for surgical exposure of a suspected early malignancy of the prostate.

An operation on the prostate having been decided upon, the patient is admitted to the hospital, and the question of drainage of the bladder immediately presents itself. If complete retention is present, a retention catheter of the Foley type is used and left inlying. If it is known or surmised that the bladder distention has been present for some time, the bladder is not immediately emptied but gradual decompression is instituted by simply raising the level of the drainage tube so that spilling over occurs only on inspiration. The purpose of this is mainly to prevent bleeding from a too sudden release of intracystic pressure. Bilateral vasectomy is performed on the institution of a retention catheter to prevent epididymitis—otherwise, it is done at the time of the prostatic surgery. Intermittent catheterization may be relied on if the residual urine is below 6 ounces or if the retention catheter is not tolerated. Prolonged drainage may also be performed with a retention catheter, suprapubic cystotomy having been done only once in this series, and that before the patient entered the hospital under our care.

The urea clearance test is done routinely for nitrogen retention determination. It is used because it is at once a record of nitrogen retention and excretion. The blood urea should be stabilized, preferably below 20 mg., and the average of the two clearance tests should also be stabilized, preferably 50 per cent or above.

Blood prothrombin time is determined and should be 70 per cent of normal or more; if it is not, vitamin K and bile salts are administered. Blood typing is done on admittance, and later the patient's blood is cross-matched so as to have blood available the day of operation.

Routine x-ray of the kidney-ureter-bladder tract and prostatic region is ordered for possible urinary tract stone, or evidence of malignant metastases. Intravenous urograms are not done routinely because of the expense to the patient but are usually done if the urine is cloudy when the patient is first seen, or if otherwise indicated.

Serum acid phosphatase determination is made when malignancy of the gland is suspected.

Urinary antiseptics are used in a prophylactic manner, such as sulfadiazine in small doses, grains 7.7 four times daily, or penicillin in wax, 300,000 units daily.

One of the prime requisites in the general condition of the patient before operation is that he should be ambulant with good vigor, a glint in his eye, if you please, and anxious to "have it over with." If a patient does not do well postoperatively, it can often be attributed to the fact that a little more time could have been spent in his preoperative preparation.

Choice of Operation

As seen from Table I, 88 per cent of this series of patients were operated upon by the transurethral route. It is thus our choice in the large majority of glands. Suprapubic prostatectomy was done in 6 per cent of the cases, usually involving a large benign gland that we estimated preoperatively to weigh 100 grams or more, in an individual in good condition. Perineal prostatectomy, done in 6 per cent of this series, includes, of course, the radical procedure for early malignancy, or the larger gland in the older, feebler patient where loss of sexual potency is not a concern and some degree of incontinence would not be a misfortune.

Anesthesia.—Spinal anesthesia is our choice, but the final choice is left to the anesthetist, to whom a great deal of credit should go for the improvement in the morbidity and mortality in all prostatic surgery. Intravenous sodium pentothal makes an ideal supplement to spinal anesthesia for the apprehensive patient.

TABLE I

		Suprapubic Prostatectomy		Perineal Prostatectomy		Transurethral Resection	
		One Stage	Two Stage	Simple	Radical	One Resection	Multiple
Total Number of Cases		5	1	4	2	81	7
Surgical Deaths		0	0	1 (86 years, 6 weeks postoperative)	0	1, aged 80, cerebral hemorrhage	0
Prolonged Morbidity		1, bladder stone	1, Poor kidney function and urethral stricture	2	1	16 with hospital stay more than 10 days	3
PERSISTENT FISTULA	Suprapubic						
	Perineal			1			
	Other						
PERSISTENT OBSTRUCTION	Stricture		1			2	
	Residual Tissue:						
	Other						1, recurring scar tissue
PERSISTENT URINARY INFECTION	Upper Urinary					2	
	Lower Urinary	1			1	3	1
INCONTINENCE				1		1	
OSTEITIS PUBIS							
PERSISTENT RESIDUAL URINE	Neurogenic					1	2
	Mechanical					2	1
Other Factors Producing Prolonged Morbidity; Epididymitis		1				8	

Operative Technique.—No attempt will be made to go into detail in technique, but we will try to point out some factors that we think are important.

The suprapubic approach is made through a transverse incision about 1 inch above the symphysis so that no scar results over the bony prominence. Exposure of the bladder is made by separating the peritoneal reflection from the bladder, facilitated by temporary Trendelenburg position. Care is taken not to disturb the prevesical space any more than necessary. The incision in the bladder is kept high and the bladder thoroughly inspected for stones, tumors, diverticula, and the size and contour of the prostate. Enucleation is carried out by blunt dissection with aid of the operator's finger in the rectum. After enucleation of the gland, the vesical orifice is thoroughly inspected and remaining tags of tissue are removed with scissors. Actively bleeding vessels are ligated or fulgurated. A No. 24 Fr. Foley catheter with 75 c.c. bag is inserted per urethra. Oxy-cell or Gel Foam is wrapped around the bag, which is then drawn into the urethra and inflated so as to fill the fossa, but not enough to distend the cavity which we believe favors the continuance of bleeding. The catheter thus holds the coagulant firmly in place. Strips of vaseline gauze are used rarely in addition to the catheter to control troublesome oozing.

A plain rubber tubing is placed in the bladder and the bladder sutured with chromic O catgut and finished in a purse string around the bladder drainage tube. This tube is removed postoperatively as soon as the urine becomes blood free—usually twenty-four to forty-eight hours. A rubber tissue drain is placed in the prevesical space and removed in forty-eight hours. The large Foley catheter is replaced by a smaller catheter in four or five days, and removed when the suprapubic wound is healed.

In perineal surgery, the same type of postoperative catheter drainage is used. In the radical operation, the vesical neck is sutured to the urethra over a Foley catheter, but a 30 c.c. bag is ample in this instance. A fortifying suture of ribbon gut between the vesical orifice and urethra, as suggested by Ormond, has resulted in good closure of the vesical orifice, with no true incontinence resulting.

Transurethral surgery is a highly technical procedure in which thorough familiarity with the posterior urethra from a cystoscopic viewpoint is essential. Unquestionably, the best results are obtained when the gland is totally removed to the capsule, as in the suprapubic or perineal approach. This should be the objective of the transurethral resection. The amount of tissue removed in this series in the single resections varied from

4.5 gram to 144 grams. The smaller amounts were found usually in the obstructive bars and carcinomas. The multiple resections (seven cases, Table II) did not represent the largest glands and serve to emphasize the fact that a small amount of remaining tissue in an important area such as the apex of the gland or roof of the urethra may be obstructive.

TABLE II

Number of Resections	Total Grams Removed
2	60
2	138
2	121
2	18
2	27
2	18
3	32

The case requiring three resections, with only a minimal amount of tissue being removed, proved to be one with recurring scar tissue, which is fortunately very rare. Personal communication with Dr. Reed Nesbit revealed that he knew of only one other similar case.

Blood loss is determined according to the method of Nesbit and Conger,[1] and the findings in forty-three cases are tabulated in Figure 1, showing the blood loss in respective cases with increasing amounts of tissue removed. In general, the greater operative blood losses occur in the larger glands, but guesswork is misleading and an estimate with standards is valuable in determining the need for blood replacement.

Following the resection, a No. 22 Fr. Foley catheter is left *in situ* with 10 to 15 c.c. of fluid in the bag, and no traction, as this seems to favor postoperative temporary incontinence. Intermittent closed irrigation with silver nitrate 1:10,000 is set up, but used only as necessary to keep the catheter and tubing patent. The catheter is usually removed on the third day.

General postoperative care in all types of prostatic surgery includes blood replacement, with frequent checks of red blood cell count and hemoglobin to assure a return to normal, and intravenous fluids as necessary to procure a urinary output of about 1,500 c.c. in twenty-four hours. Ambulation is encouraged as soon as the urine becomes blood free, whether drainage is in place or not. Urinary antiseptics, such as sulfadiazine and penicillin (either water-soluble or oil and wax preparations) are used quite freely pre- and postoperatively and are invaluable.

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Medical Treatment of Perforated Peptic Ulcer

Report of a Case

By Robert S. McClintock, M.D.
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THIS CASE IS of unusual interest because it is the practice in the Baltimore Marine Hospital to treat all ruptured peptic ulcers conservatively. It is one in a series of more than thirty-five cases with only one death, treated by conservative measures by Dr. J. D. Lane.[6]

It is of further interest because the patient developed and maintained for many weeks a large, asymptomatic, localized abscess of the peritoneum, apparently caused by spilled gastric juice.

To review the subject of ruptured peptic ulcer briefly, we note that the incidence is seasonal, chiefly in the spring and fall; that it affects males in more than 90 per cent of the cases; and that there is usually a preceding history of indigestion or of gastric distress. The etiology is as yet undetermined. The pathologic process is an erosion ulcer that extends through the mucosa, muscularis, and finally through the serosa of the stomach or duodenum.

The mortality rate is affected by several important factors:

1. The literature[3,7] maintains that the time interval between the occurrence of perforation and the closure of the leak by operation is the most important factor in mortality. If the time interval is over twenty-four hours, the over-all mortality is upwards of 50 per cent.

2. The size of the perforation is the second factor.

3. The status of digestion at the time of the perforation is a factor, as maintained by Wangensteen and Paine.[10]

Dr. McClintock was formerly S. A. Surgeon, U. S. Public Health Service, stationed at U. S. Marine Hospital, Baltimore, Maryland.

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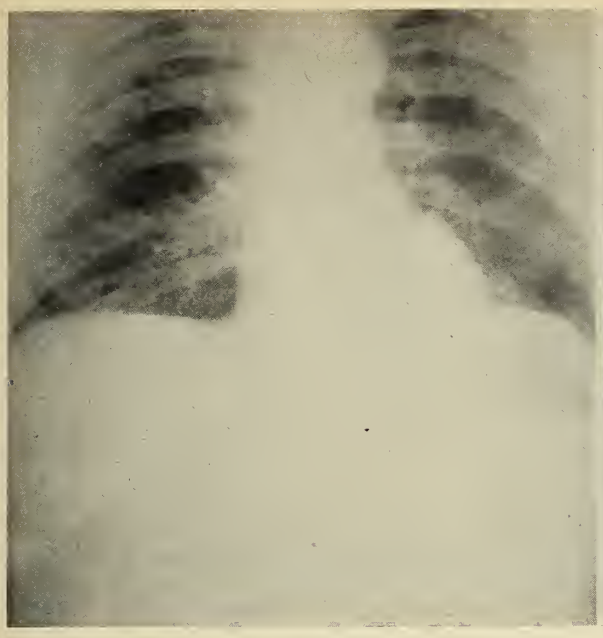

Fig. 1. Roentgenogram taken five hours after perforation on December 14, 1945, shows no free air under the diaphragm.

Fig. 2. Roentgenogram taken on December 21, 1945, shows free air under both leaves of the diaphragm.

4. Lastly the general condition of the patient is a very important factor.

In the last twenty years the mortality rate for nearly all series of perforated peptic ulcers varies from 3 per cent to 33 per cent. The country averaged 26 per cent in 1930 and 23.7 per cent in 1939, according to a review of this condition by DeBakey in 1940.[3] According to Thompson[12] mortality varies from 0 to 85 per cent. Needless to say, this is a high rate and one is justified in attempting drastic means in order to lower it. That conservative treatment measures and chemotherapy in adjunct to surgery have lowered this figure is realized in the recent report by McCarthy and Knoepp.[8] They have the lowest available mortality figures, 3 per cent, or one death in twenty-eight cases operated upon. Graham and Tovee[4] reported a mortality of 6.3 per cent in 114 cases.

The diagnosis of a perforated peptic ulcer is generally not difficult. In the great majority of cases there is a preceding history of peptic ulcer. The disability and sudden excruciating pain of a perforation are outstanding symptoms. The abdomen soon becomes as rigid as a board. Clinical shock generally is not seen.

Until now, the accepted treatment for perforation has been immediate operation. Most surgeons who write on the subject agree with Moynihan in surgically investigating every acute abdominal condition. Bloomfield,[2] discussing the indication for operation in cases of peptic ulcer, does not even mention perforation!

However it is not rare to find reports in the literature of cases, mostly isolated ones, of perforated ulcer treated conservatively, and not uncommonly with recovery.[9]

There are many such cases in the foreign literature. In 1926 Singer[11] reports a recovery rate of from 1 to 5 per cent in cases of perforated peptic ulcer treated without operation, but he advised all to have an operation performed. Hadley[5] treated a case with recovery and reported it in 1940.

Wangensteen[13] has reported eight cases treated conservatively with one death in 1935. He believed that the typical patient with only minimal findings may be treated without operation, but that the patients seen late with diffuse findings and signs of localization should not be operated upon.

In the panel discussion of peptic ulcer in the *Journal of the American Medical Association,* 1942,[1] Dr. Mullen mentioned that twenty-eight cases have been treated conservately by a group of physicians in Seattle, but that they have not published their results (death in three cases) because the subject matter was too touchy.

For several years it has been the policy of Dr.

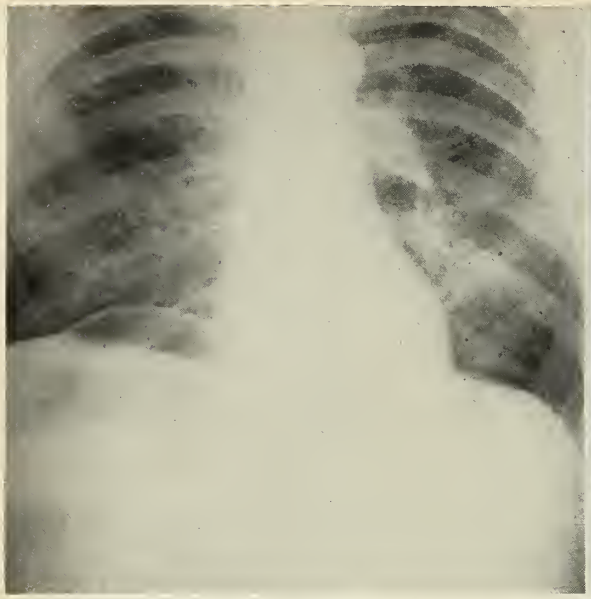

Fig. 3. Roentgenogram taken on January 17, 1946, shows the large cyst-like cavity containing fluid and air.

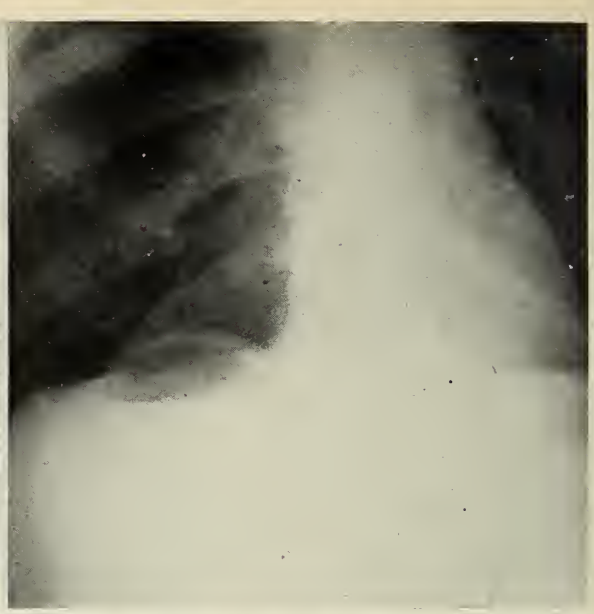

Fig. 4. Roentgenogram taken on February 15, 1946, shows the cavity much reduced by the aspiration of February 8, 1946.

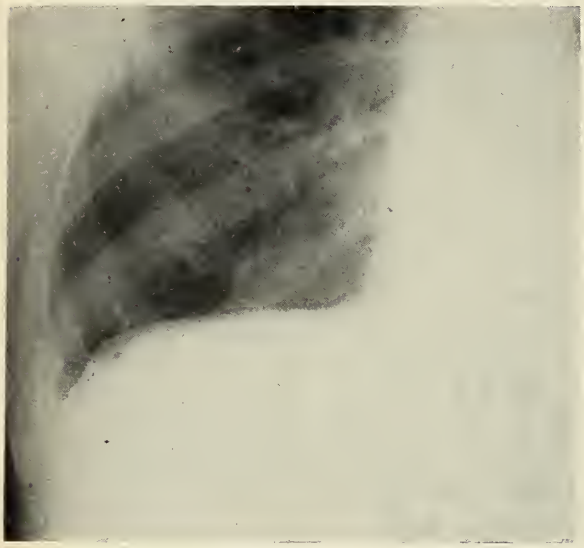

Fig. 5. Roentgenogram taken on March 22, 1946, shows the complete disappearance of the cavity.

J. D. Lane to treat all cases of perforated peptic ulcer without operation. It has been my privilege to help carry out his form of treatment in many patients with perforations at this hospital in the last eighteen months.

Case History

This unusual case of perforation is that of F.L.B., a fifty-two-year-old white merchant seaman, admitted to this hospital, on the surgical service, December 14, 1945, at 4 p. m., complaining of severe abdominal pain beginning four hours before admission. For many years he had symptoms of stomach trouble, indigestion, gas and food intolerance, and had been taking soda daily for relief of symptoms. At 11 a. m. December 14, he had eaten his usual lunch, chiefly navy beans. Indigestion developed and he was soon incapacitated by a sharp severe upper abdominal pain.

On physical examination there appeared a well-developed, not very well nourished, white man in acute distress. His skin was dark tan and slightly cyanotic. Temperature was 36.6°C. Pulse was 90 and of good volume. Blood pressure was 140 systolic and 90 diastolic. The peripheral vessels were firm and tortuous. The heart and lungs were essentially normal except for emphysematous-type chest. The abdomen was board-like in consistency, and exquisitely tender in the epigastrium.

Laboratory studies revealed a 10,400 white blood cell count. Serum protein was 4.9 grams. An upright roentgenogram of the abdomen was not remarkable. An electrocardiogram showed nonspecific myocardial damage.

During the hospital stay of five weeks this patient was treated medically. He received morphine sulfate, grains ¼, on three occasions for pain during the first two days. He was given 7.5 grams of sulfadiazine intravenously daily for the first five days, and then 1 gram every four hours orally for the following eight days. He also received intramuscular penicillin, 20,000 units every three hours for twelve days. Continuous Wangensteen gastric suction was started immediately, and used for six days.

The patient was gradually and completely relieved of all abdominal pain within twenty-four hours. The abdominal rigidity had disappeared in forty-eight hours, but not the tenderness in the epigastrium. On the third day the right hypochondrium was noted to be full and tender. A roentgenogram of this area revealed a localizing abscess containing fluid and air. However despite

this and an elevated temperature, ranging from 37° C to 39°C, the patient appeared very comfortable after his second day in the hospital. His temperature was elevated for two weeks. During the first week of hospitalization, caloric and vitamin requirements were maintained, using parenteral routes. After the Wangensteen tube was removed, he was put on a Sippy regime, and the diet was rapidly advanced so that he had a general diet with ulcer restrictions within three weeks. His pulse remained around 100 during the entire stay.

A large abscess did develop in the right subdiaphragmatic area anteriorly, the fluid level measured 17 cm. on December 21, 1945. The persistent chemotherapy probably prevented a more toxic course or even a frank purulent exudative process. The prevention of abscess formation and/or peritonitis is the rational of the intensive course of chemotherapy. Despite the persistent pocket of fluid and air, the patient was clinically well and entirely without symptoms.

A gastrointestinal series of January 14, 1946, revealed a grossly irregular duodenum. He was discharged from the hospital on January 19, improved and with ulcer diet instructions. He stated that he "never felt better."

He was followed as an outpatient, and the cavity with fluid was slowly absorbing. It was aspirated of 60 c.c. of yellow, gastric juice-like material on February 8, 1946. This specimen was cultured, but found to be sterile. The man remains well and eats a general diet. As seen in the serial reproductions of the roentgenograms, there was no evidence of subdiaphragmatic abscess or of fluid on March 22, 1946. A checkup examination on June 6, 1946, showed a much improved duodenum on examination with barium, compared to the previous gastrointestinal series. A gastric analysis on this date revealed normal gastric acidity.

It is believed that effective gastric syphonage and chemotherapy are the keystones to the successful medical management of perforated peptic ulcer cases. The continuous Wangensteen suction deflates the stomach, stops further spillage from the stomach and upper duodenum, and allows the processes of healing to close the perforation. Chemotherapy, consisting of sulfonamides, penicillin, or streptomycin, or any combination of these agents, apparently will prevent abscess formation and peritonitis as illustrated in this case.

Summary

There is here presented a case of perforated peptic ulcer, which is one in a series of many being treated routinely without operation in the U. S. Marine Hospital at Baltimore. In spite of a poor condition generally, and the development of a localized cavity of fluid, this patient recovered completely with the employment only of the conservative measures mentioned.

(Continued on Page 1322)

Combined Jaw Resection and Neck Dissection

By Harry C. Saltzstein, M.D., and
Walter Johnson, M.D.
Detroit, Michigan

H. C. Saltzstein

THE OPERATION of surgical removal of intra-oral cancer combined with neck dissection was performed and written about by some of the earlier surgeons, notably Kocher, Bloodgood, and others. The mortality was high: easily 20 per cent. With the advent of irradiation therapy it was quite generally discontinued.

The passage of time has allowed more exact evaluation of irradiation. During the past one or two decades, advances in general surgery have allowed us to operate for hours without shock and with the avoidance of the usual complications which previously made such operations hazardous. There has been a renewal of interest in wide *en block* surgical removal of mouth and neck malignancy. Carcinoma involving the mandible is hopeless under any other treatment than wide surgical removal. Intra-oral lesions close to the mandible do poorly under irradiation or other intra-oral removal. Also large neck masses, if still operable and not fixed, with intra-oral lesions uncontrolled, are being put into the category of candidates for block dissection of neck, mandible, and the intra-oral lesion in one stage. Slaughter defines the indications as follows: when bone is involved by intra-oral cancer and when there are operable unilateral cervical node metastases, there is definite indication for excision of the soft tissue primary, the involved jaw, and a neck dissection in continuity.[3]

At the Memorial Hospital, New York City, the operation is colloquially called the "commando" and since 1942 has been applied to an increasing number of growths originating in the mouth. These include carcinoma primary in the floor of the mouth, carcinoma of the tongue involving the floor of mouth tonsillar pillar or mandible, the buccal mucosa close to mandible, the alveolar

ridge, et cetera. Although five-year results are not yet available, preliminary surveys already show a significant increase in survival rates.[1]

Extensive fungating lip carcinomas densely attached to or invading the mandible, though locally extensive, may spread below the hyoid region very slowly. They are suitable for block neck dissection plus excision of the involved portions of the mandible and the entire lower lip, in one mass, and subsequent plastic repair. Sugarbaker and Gilford from Missouri State Cancer Hospital published a series of twelve such combined resections in December, 1946.[4] Most of their cases were extensive submaxillary and submental triangle masses densely fixed to the mandible, usually originating from the lip, all of them hitherto considered hopeless. There were two postoperative deaths, and "although the followup period was short, even patients alive without recurrence, from sixteen to forty-five months after the treatment, suggest an ultimate prognosis far different from the relatively hopeless outlook formerly existing for these patients."

Knight, of Wangensteen's clinic, Minneapolis, in a recent article on anesthesia speaks of "three-quarters mandibulectomy, massive neck dissection and skin graft. The anesthesia (pentothal, curare, nitrous oxide and oxygen) was exactly eight hours."[2]

The following two cases are presented as illustrating this method of approach. Although tedious and time-consuming in practice, it bids fair, we think, to be an advance over our previous efforts for the cure of these patients.

Case Reports

Case 1.—A. G. was a stocky Italian workman, aged sixty-three, in apparently good health except for a local lesion in the mouth. The office description of the local lesion was as follows March 3, 1947: "There is an ulcer on the left side of the posterior portion of the tongue at about the junction of the anterior pillar and the mandible. The ulcer is about 1.5 cm. in diameter and there is a raised, rolled edge. It penetrates posteriorly, exposing some of the inner surface of the bone at the angle of the mandible. The limit of the posterior margin of the ulcer is the anterior pillar of the fauces. Here there is some induration. The lateral border is the exposed gingival surface of the mandible, and mesially it extends out onto the base of the tongue. There is some pyorrhea, some induration and a questionable gland in the posterior submaxillary region of the neck. Microscopic biopsy: squamous cell carcinoma."

These intra-oral lesions of the posterior portion of the tongue, in our experience, do poorly under intraoral therapy. When the mandible is exposed and the bone bare, the amount of irradiation which the patient can stand is limited. There is a high percentage chance of spreading rapidly into the neck, and the results of intraoral therapy followed by subsequent neck dissection are not good.

It was decided to do a complete block dissection on the left side of the neck, plus a left hemimandibulectomy plus a wide local excision of the lesion in one stage and one complete dissection. This was done on March 12, 1947.

Exposure was through the Crile incision (a curved incision starting at the mastoid eminence, curving downward and forward to the hyoid bone and then curving upward to the midline of the chin. Then a vertical incision was made from the mid-point of the above incision at the hyoid downward to 2 inches below the clavicle). The flaps were dissected back mesially to the mid line, upward to above the mandible, posteriorly to the trapezius. The platysma was included with the flaps. Dissection was begun just above the clavicle. The sternomastoid was divided, the jugular separated and ligated, and the incision deepened dissecting down to the scalene muscles exposing the phrenic and the vagus nerves. The mass of sternomastoid, supraclavicular triangle contents, et cetera, was then dissected upward cleaning everything from the edge of the strap muscles (anteriorly) to the trapezius (posteriorly). At the level of the hyoid, the lingual vein was divided, the external carotid artery was divided, and the jugular bulb region exposed by dividing the posterior portion of the digastric muscles. The upper attachment of the sternomastoid muscle was divided; the jugular vein was separated and divided at its emergence from the base of the skull; the lower pole of the parotid cut through. Then the structures behind the ascending ramus of the mandible were cleared, and the ascending ramus separated away from the constrictor muscles of the pharynx to facilitate subsequent excision of the mandible.

The midline incision was then carried upward to the mid point of the vermillion border of the lip. The flap of the left side of the face was dissected away from the mandible and the mandible was divided just back of the canine tooth on the left side. The growth in the mouth was then easily accessible. When exposed, it was found to be an extensive crater ulcer fully twice as large as had been apparent on oral examination. It was 3 cms. in diameter. It involved some of the anterior pillar, spread over the inner surface of the mandible near the angle, and exposing bare bone and extended onto the floor of the mouth to the mid portion of the submaxillary triangle. It was widely excised. The excision included a portion of the tongue, the pharyngeal constrictors and the tonsillar region, and a small portion of the palate. The growth apparently had not extended very widely beyond visible ulceration. There was one small gland posterior to the submaxillary triangle. On pathological examination this proved to be simply a hyperplastic lymph node and not involved with carcinoma. The left side of the mandible was then removed by cutting through the pterygoid muscles, close to the ascending ramus and disarticulating at the temporomaxillary joint

(Fig. 1, A and B.) The mouth defect was repaired as well as possible. The left side of the tongue had to be sutured to the palate and also high up onto the buccal surface. Wound in the neck closed. Convalescence was relatively uneventful after some discharge and perhaps a

Fig. 1 A. (Case 1) Photograph of specimen. Complete contents of all neck triangles, hemimandibulectomy, wide removal of intra-oral lesion close to mandible in one block, in continuity.

small amount of leakage from the mouth which cleared in a few days. There was some shifting to the left of the mandible, due to the high suturing of the left side of the tongue. However, this was corrected with an interdental splint, worn for a few weeks.

On June 1, 1947, the patient could masticate soft foods. The neck was well healed and with the exception of some weakness of the left side of the tongue he is o. k.

Case 2.—J. F., aged sixty, was first seen October 10, 1946. In March, 1946, patient had a "cold" and then he noticed a gland in the left side of his neck. There was no tenderness at first. About two or three weeks after having noticed the mass in the neck he noticed a sore on the left side of his tongue. At the time he was seen, he did not think the sore had grown, and even thought the lesion in the mouth was a trifle better.

Examination revealed a rather heavy (200 pounds) man, aged sixty, with blood pressure of 150 and moderate diabetes. The local lesion in the mouth was described as follows: "On the left side along the inner border

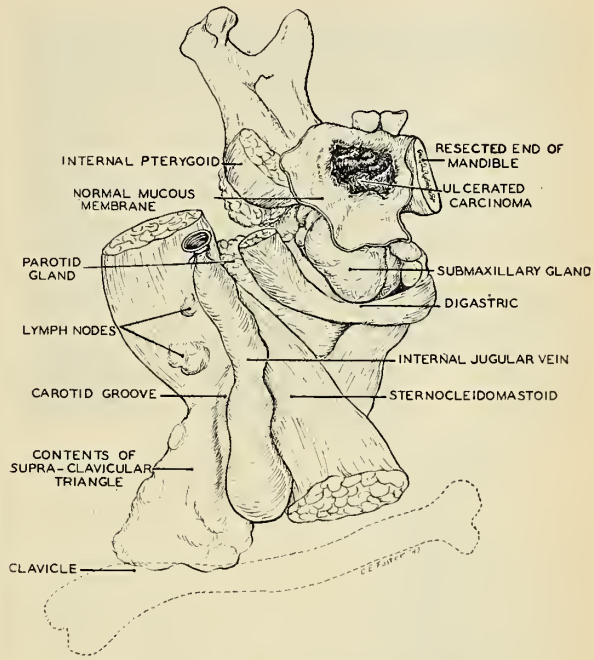

Fig. 1 B. Explanatory line drawing.

of the ascending ramus and the anterior tongue pillar is an irregular ulcerated area about 2 cm. wide and about 1 cm. in vertical diameter. It extends medially onto the soft palate, laterally to the outer border of the gingival margin of the mandible. The outer portion over the mandible is nodular and irregular.

"In the neck there is a large dense firm mass lying beneath the sternomastoid in the upper portion of the neck, fully 2 inches in diameter, immediately behind the angle of the jaw. It is quite dense, firm and movable laterally but not vertically. The upper border is close to the tip of the mastoid process. There is another gland palpable anterior to this and below the angle of the mandible about 1 cm. in diameter."

Lesions in the posterior portion of the mouth with large metastases in the neck heretofore have offered a very poor prognosis by any method of treatment. Though the lesion in the mouth might have been controlled by irradiation, in our experience a gland of this dimension in the neck is not affected by radiation therapy except for a certain amount of shrinkage and fibrosis. Also a block dissection of the neck with a neck gland so close to the original lesion is apt to cut through metastatic channels and again in our experience has not proved satisfactory. It was decided, despite his age and diabetes, to attempt a combined radical neck dissection and mandible excision. This was done, the procedure being similar to that of Case 1. The mandible was divided in the mid line. The metastatic growth in the neck was densely adherent to the jugular

bulb and the structures immediately posterior to it. It was difficult to clear it from the bulb, and it was not certain that all of the growth had been circumscribed with a margin of normal tissue immediately posterior to the jugular vein. When the specimen was re-

Fig. 2, A and B. (Case 2) Minimal deformity following hemimandibulectomy, wide removal of intra-oral cancer and radical complete neck dissection in one complete mass. Note that facial and oral lines of expression are intact, and right side of lower jaw occludes well with right upper jaw.

moved, the lesion in the mouth was about 1 cm. in diameter. The node in the neck was described as "5 x 4 x 3 cm." Another cystic node was 2.5 cm. in diameter. Microscopic diagnosis was "widely infiltrated highly anaplastic squamous cell carcinoma. Prognosis, hopeless." Convalescence was rather stormy for a time. A rather active infection developed which produced a 1 cm. fistula into the mouth. This was difficult to heal because of the diabetes, and a gastrostomy was done for feeding. The patient was sent home with his gastrostomy, and the wound in the face and neck slowly healed. Patient was brought back on January 17, 1947, and the gastrostomy was closed as an ambulant procedure, the patient going home immediately. At the present time (June 1, 1947) he has completly rehabilitated himself. He actively carries on his small tailor shop. There is still a small sinus behind the ear, but the drainage from here is minimal. He masticates soft food. Otherwise he maintains his health and has gained weight (Fig. 2 A and B).*

Comment.—Recurrence took place high in the neck, close to the mastoid eminence and behind the jugular bulb.

Except for this one area, where the dissection encountered unusual difficulties, the entire field was clear and free from disease.

Summary

Two cases of intraoral cancer are presented in which complete block neck dissection plus hemimandibulectomy and wide excision of the intraoral lesion was done in one stage. The indications for the operation are briefly discussed.

References

1. American College of Surgeons: Case demonstration at meeting in New York, September, 1947.
2. Knight, Ralph T.: Corollary in anesthesia. J. Indiana M. A., 40:125, (Feb.) 1947.
3. Slaughter, Danley P. (Director Tumor Clinic, Research and Education Hospital, Chicago): Personal communication.
4. Sugarbaker, E. D. and Gilford, Jack: Combined jaw resection and neck dissection for metastatic carcinoma of cervical lymph nodes secondarily involving the mandible. Surg., Gynec. & Obst., 83:767, (Dec.) 1946.

*About July 1, 1947, pain in the left side of the face required empirin and codein.

On September 27, 1947, alcohol injection of the fifth nerve was done (Dr. F. Schrieber). It was unsuccessful. Exploration, October 6, 1947 revealed metastatic carcinoma underneath the parotid gland in the upper posterior portion of the wound in close to the mastoid eminence.

PROLAPSE OF THE UMBILICAL CORD

(Continued from Page 1279)

The author wishes to thank Dr. Arthur K. Northrop Sr., and Dr. Edward Sieber for valuable assistance in the preparation of this paper.

References

1. Bourgeois: Am. J. Obst. & Gynec., 41:837, 1941.
2. Caldwell: Obstetrics and Gynecology (Curtis). Philadelphia: W. B. Saunders Co., 1937.
3. Gusberg: Am. J. Obst. & Gynec., 52:5, 1946.
4. Kurzrock: Am. J. Obst. & Gynec., 23:403, 1932.
5. McCormick: Pathology of Labor, the Puerperium, and the Newborn. St. Louis: C. V. Mosby Co., 1944.
6. Mengert and Longwell: Am. J. Obst. & Gynec., 40:79, 1940.
7. Peterson, R., and Miller, N. F.: A Manual for a Demonstration Course in Obstetrics. Ann Arbor, Michigan: Edwards Bros., 1940.
8. Shears: Obstetrics, Normal and Operative. Third edition. Philadelphia: J. B. Lippincott Co., 1920.
9. Titus: Management of Obstetric Difficulties. St. Louis: C. V. Mosby Co., 1937.
10. Williams: Obstetrics. Edited by Stander. Seventh edition. New York: Appleton-Century Co., 1936.

PROSTATIC SURGERY

(Continued from Page 1282)

Prince[2] has shown their value in a more rapid clearing of the urine, thus decreasing the morbidity.

Feeding of the patient is important, and adequate protein intake as soon as possible is advisable, and adequate fluid food intake by mouth as soon after operation as possible is urged.

Pain is usually not a troublesome feature, demerol hypodermically having proved very valuable for analgesia and sedation. In fact, most patients undergoing prostatic surgery today feel they have been disillusioned regarding its discomforts and thus are more frequently presenting themselves for treatment before irreparable damage to the upper urinary tract has occurred.

Summary

An analysis of 100 consecutive cases of prostatic surgery is presented with a surgical mortality of 2 per cent. Some of the salient features in the care of these cases are discussed.

References

1. Nesbit, R. M., and Conger, Kyril B.: Studies of blood loss during transurethral prostatic resection. J. Urol., 46:713-717, (Oct.) 1941.
2. Prince, Chas. L.: The prevention of urinary tract infection following transurethral prostatic resection by combined use of sulfadiazine and penicillin. J. Urol., 56:121, (July) 1946.

Postgraduate Facilities

The 82nd Annual Session of the Michigan State Medical Society was recently held in Grand Rapids. Fourteen hundred and one Doctors of Medicine registered for the Scientific Session. This was a splendid expression of the interest of our members in the Science of Medicine; and a fine tribute to our guest speakers, showing full appreciation of the high caliber of their presentations.

It is wholesome and encouraging to know in these days of postwar unrest and fatigue from overwork during the war that our members are keeping constantly abreast of the scientific advances in medicine.

The Michigan State Medical Society working with other groups sponsors four main types of postgraduate medical education:

1. The Annual Scientific Assembly in September.
2. The Postgraduate Clinical Institute in March.
3. The special programs of the School of Medicine of University of Michigan and Wayne University College of Medicine.
4. The short one-day to two-day programs given at our various postgraduate centers throughout the state.

We should take advantage of all these facilities. This will pay dividends in better work, satisfied patients, and, therefore, increased prestige.

P. L. Sedwidge

President, Michigan State Medical Society

President's

Page

Editorial

EIGHTY-SECOND ANNUAL SESSION

THE EIGHTY-SECOND Annual Session of the Michigan State Medical Society is history. Grand Rapids cannot be surpassed for convenience and availability of hotel, meeting places, assembly halls, and space for scientific and technical exhibits. The arrangement, practically all under one roof, is as near perfection as can be asked. The underground passage to the hotel adds to convenience and assures protection from unfavorable weather. But beautiful weather graced the 1947 session.

One of the most outstanding programs ever seen in the forty-five years of the modern Michigan State Medical Society was presented. There were thirty-two out-of-state speakers, leaders in their fields, who covered quite thoroughly the fields of practice. These men gave of their best, with papers prepared for the general assembly, for the listening pleasure of all our members. Many of them also presented technical papers to the sections at noon meetings, and were prepared to answer questions on their papers or any other questions for which there was time, at the twenty-three discussion conferences.

Seven general assemblies were held, with twenty-seven addresses by out-of-state speakers; twelve section meetings, with addresses by out-of-state speakers; and twenty-three discussion conferences, which were presided over by chairmen of distinction, and at which the guest essayists were free for questioning.

The general assembly on Wednesday evening was a public meeting, with reports of elections, reports of the House of Delegates, President's Address (William A. Hyland, M.D., Grand Rapids), induction of the new president, P. L. Ledwidge, M.D., Detroit, and introduction of the president-elect, E. F. Sladek, M.D., Traverse City. Other re-elected and newly elected officers were introduced. Distinguished Health Service Awards were presented to Charles F. Kettering, Detroit, and to the Michigan Society for Crippled Children and Disabled Adults, for noteworthy and outstanding achievements in the cause of health.

Ninety-nine awards and certificates were issued to charter members of the "Fifty Year Club."

The Honorable John Nicholas Brown, Washington, D. C., Assistant Secretary of the Navy for Air, gave the Andrew P. Biddle Oration on "Human Engineering." Mr. Brown was presented with the Biddle Oration Scroll.

A necessary part of the Annual Session included the meetings of the Council, starting Saturday evening, September 20, 1947, and finishing Thursday, September 25, 1947, with the election of a new chairman, O. O. Beck, M.D., of Birmingham.

The House of Delegates went into annual session Sunday, September 21, and completed its business Tuesday noon. A program held Wednesday afternoon, September 24, was the Medical Assistants Conference, which was addressed by L. Fernald Foster, M.D., Bay City, secretary of the Michigan State Medical Society; Jay C. Ketchum, Detroit, executive vice president, Michigan Medical Service; Hugh W. Brenneman, Lansing, Public Relations Council, Michigan State Medical Society; and J. Duane Miller, M.D., Grand Rapids, Councilor, Fifth District, Michigan State Medical Society.

Motion pictures on surgical subjects were in almost continuous performance, since there were nearly sixty films.

The Woman's Auxiliary of the Michigan State Medical Society held a three-day active session.

The Eighty-Second Annual Session was a great show!!

ORGANIZATION SEMINARS

THE SIXTEEN COUNCILORS of the Michigan State Medical Society were invited by The Council, in formal session in July, 1947, at Traverse City, to arrange "Organization Seminars" in the various counties of their districts, to take place of the district meetings and State Society Nights that have been held in the past.

These seminars will begin with a roundtable discussion of socio-economic problems facing the medical profession; this will be entered into by the Michigan State Medical Society officers present, and the president, secretary, and editor of the county medical society. This one-hour panel will be followed by a dinner meeting of all the members

of the county medical society, at which two, or at most three, ten-minute talks will be presented by MSMS officers.

Local problems as well as information on state and national matters are to be presented to the physicians. Stressing local situations and seeking their solution will make for greater interest. Such meetings will bring an abundance of information to the county, and will stimulate many men now only concerned in practice to take a more active and aggressive interest in the great problems that must be settled in the near future.

Requests for "Organization Seminars" should be, and are being made by county or district medical societies, merely upon application to their Councilor.

The first Organization Seminar is scheduled for Berrien County, in southwestern Michigan on Monday, December 3, 1947, at Niles. By the time this is published several others will be scheduled, but it will not be too late for your county.

Schedule an "Organization Seminar" and learn "what's doing."

PRESIDENT-ELECT SLADEK

THE NEW PRESIDENT-ELECT of the Michigan State Medical Society has advanced his services to the Society and his opportunities for more services.

Edward F. Sladek was born in Chicago, Illinois, July 12, 1895, and was graduated from the University of Illinois, A.B., 1916, and M.D., 1918. After interning in Michael Reese Hospital, he entered the practice of medicine in Traverse City in November, 1919. He was secretary of Grand Traverse-Leelanau-Benzie County Medical Society thirteen years, 1925 to 1938, and president in 1930. He served as member of the House of Delegates of the Michigan State Medical Society 1928-1938 when he was elected to The Council. He has served on the Executive Committee of the Council from 1942 to date, being chairman from 1944 to 1947.

Dr. Sladek has been just as active in scientific and other forms of medical service. He is a Fellow of the AMA, and of the International College of Surgeons, a member of the American Proctological Society, secretary of the National Conference on Medical Service, vice chairman of the Associated States Postgraduate Committees, a member of the Board of Trustees of Michigan Medical Service, besides holding membership in many fraternal and civic organizations and committees.

Of his hobbies Dr. Sladek says they were formerly fishing and golf, but now they are of necessity organized medicine and medico-socio-economic problems. Last year he devoted seventy-six days of his busy practice to the organizational activities of the Michigan State Medical Society and other medical associations.

The Michigan State Medical Society is fortunate in its selection of a new president-elect. We know he will work—he has in the past—with sacrifice and devotion.

COUNCILOR OAKES

ELLERY A. OAKES, M.D., of Manistee, Michigan, is the new representative on the Council from the Ninth District, but he comes as an old and tried friend. He was born in East Tawas, Michigan, in 1894, was graduated, A.B., Albion, 1920, and M.D. from Wayne University, in 1925. He interned at Receiving Hospital, Detroit, then practiced in Homer, Michigan, and moved to Manistee in 1927. He has done postgraduate work in New York. For fifteen years he served as delegate, and for two years was vice speaker of the House of Delegates. As a non-medical activity he is a past president of Rotary.

The Council will be the gainer in this advancement of a hard worker.

ON THE RUN . . . . .

Retention of ten pounds of water can occur without visible edema.

. . .

Adequate use of digitalis after acute left ventricular failure is helpful in preventing future attacks as well as in controlling cardiac irregularities.

. . .

Any therapeutic effort designed to lower blood pressure in hypertensives must be appraised as to its effect on renal function.

. . .

Ergotamine tartrate is contra-indicated in septic states cardiovascular and obliterative vascular disease.

. . .

Precordial pain from strain of the pectoralis minor muscle may be differentiated from intrathoracic or cardiac disease by (1) reproduction of the pain on pushing the upper arm forward against resistance and (2) disappearance of the pain following injection of procaine at the point of greatest tenderness.

Selected by W. S. Reveno, M.D.

Postgraduate Continuation Courses

Wayne University College of Medicine

December 8, 1947 — March 13, 1948

These courses are open to all qualified persons.

Veterans who are not Residents in a Detroit Hospital should make arrangements for tuition and books, as provided by the G.I. Bill, with Mr. Arthur Johnson, Veterans Administrator at Wayne University, 5063 Cass Avenue. **This must be completed before you register.**

Registration for these courses can be made in the office of Postgraduate Medical Education at the College of Medicine, 1512 St. Antoine, before December 5.

ANATOMY			
Surgical Anatomy	College of Medicine	Tuesday 3-5 P.M.	$35.00
(Limited to 20 Senior Surgical Residents)			
Advanced Histology	College of Medicine	Monday 2-5 P.M.	$35.00
PATHOLOGY			
Beginning Hematology	College of Medicine	Monday 1-5 P.M.	$35.00
Neuropathology	College of Medicine	Friday 1-5 P.M.	$35.00
Pathology of Neoplasms	College of Medicine (Limited to 50)	Wednesday 1-5 P.M.	$35.00
Advanced Hematology	College of Medicine	Friday 1-5 P.M.	$35.00
(Limited to 5; Prerequisite—Beginning Hematology)			
PHYSIOLOGICAL CHEMISTRY			
Seminar	College of Medicine	Wednesday 4-5 P.M.	$15.00
Physical Chemical Aspects of Biochemistry	College of Medicine	Tuesday and Thursday 3-4 P.M.	$25.00
PHYSIOLOGY			
Survey of Physiology	College of Medicine	Friday 4-5 P.M.	$15.00
DERMATOLOGY			
Seminar	Receiving Hospital	Wednesday 10-11:30 A.M.	$15.00
Conference on Venereal Diseases	Social Hygiene Clinic	Thursday 4-5:30 P.M.	$15.00
Superficial Mycoses	Receiving Hospital	Thursday 9:30-12 M.	$35.00
INTERNAL MEDICINE			
Medical Pathologic Conference	Receiving Hospital	Saturday 11-12 M.	$15.00
	Wayne County General	Thursday 11-12 M.	$15.00
Diagnostic Conference	Wayne County General	Tuesday 4-5-P.M.	$15.00
Beginning EKG	Wayne County General	Friday 11-12 M.	$15.00
Gastroenterology Clinic Hematology Clinic	Receiving Hospital	Wednesday 1-2 P.M.	$15.00
Medical X-Ray Conference	Receiving Hospital (Limited to 10)	Tuesday 11-12 M.	$15.00
	Wayne County General	Friday 1-2 P.M.	$15.00
Allergy Clinic and Conference	Receiving Hospital	Tuesday 8-11 A.M.	$25.00
SURGERY			
Seminar	College of Medicine (Limited to 20)	Thursday 4-5 P.M.	$15.00
OPHTHALMOLOGY			
Basic Ophthalmology	College of Medicine (Limited to 20)	Full Time	$300.00
(Beginning January 15 through June 15, 1948)			

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XV. Adjournment		

MICHIGAN STATE MEDICAL SOCIETY

Eighty-second Annual Session

PROCEEDINGS OF THE HOUSE OF DELEGATES

Pantlind Hotel, Grand Rapids, Michigan

First Meeting

Sunday Afternoon, September 21, 1947

The eighty-second Annual Session of the House of Delegates of the Michigan State Medical Society, held at the Pantlind Hotel, Grand Rapids, Michigan, on September 21-23, 1947, convened at 2:00 p.m., J. S. DeTar, M.D., Speaker of the House of Delegates, presiding.

THE SPEAKER: Will the House please come to order? I would like to ask the Chairman of the Credentials Committee to come to the platform and report.

J. J. O'MEARA, M.D. (Jackson): Mr. Speaker, I have here the credentials of eighty-seven members, which is more than the necessary number for a quorum, 50 per cent of whom are not from any one county.

THE SPEAKER: If there is no objection the roll call will be dispensed with and the report will be accepted.

I. Record of Attendance

OFFICE	OFFICER	MEETING 1st	2nd	3rd	4th
Speaker	J. S. DeTar	x	x	x	x
Vice Speaker	R. H. Baker	x	x	x	x
Secretary	L. Fernald Foster	x	x	x	x
Immediate Past President	R. S. Morrish	x	x	–	–
COUNTY	**DELEGATE**				
1. Allegan	O. D. Hudnutt	x	x	x	x
2. Alpena	W. E. Nesbitt	x	x	x	x
3. Barry	A. B. Gwinn	x	x	x	x
4. Bay	A. D. Allen	x	x	x	x
	W. S. Stinson	x	x	x	x
5. Berrien	D. W. Thorup	x	x	x	x
6. Branch	R. L. Wade	x	x	x	x
7. Calhoun	B. G. Holtom	x	x	x	x
8. Cass	S. L. Loupee	x	x	x	x
9. Chippewa-Mackinac	B. T. Montgomery	x	x	x	–
10. Clinton	T. Y. Ho	x	x	x	x
11. Delta-Schoolcraft	A. H. Miller	x	x	x	x
12. Dickinson-Iron	D. R. Smith	x	x	–	x
13. Eaton	G. C. Stucky	x	x	x	x
14. Genesee	A. H. Kretchmar	x	x	x	x
	J. E. Livesay	x	x	x	x
	A. C. Pfeifer	x	x	x	x
	A. N. Thompson	x	x	x	x
15. Gogebic	W. L. Maccani	Not Repres'd.			
16. Grand Traverse-Leelanau-Benzie	C. E. Lemen	x	x	x	x
17. Gratiot-Isabella-Clare	M. G. Becker	x	x	x	x
18. Hillsdale	L. W. Day	x	x	x	x
19. Houghton-Baraga-Keweenaw	A. M. Roche	x	x	x	x
20. Huron	C. W. Oakes	x	x	x	x
21. Ingham	R. S. Breakey	x	x	x	x
	L. C. Christian	x	x	x	x
	H. W. Wiley	x	x	x	x
22. Ionia-Montcalm	M. M. Hansen	Not Repres'd.			
23. Jackson	C. S. Clarke	x	x	x	x
	James J. O'Meara	x	x	x	x
24. Kalamazoo	R. J. Armstrong	x	x	x	x
	L. W. Gerstner	x	x	x	x
25 Kent	R. H. Denham	x	x	x	x
	Harry Lieffers	x	x	x	x
	W. B. Mitchell	x	x	x	x
	L. E. Sevey	x	x	x	x
	Andrew VanSolkema	x	x	x	x
	A. V. Wenger	x	x	x	–
26. Lapeer	D. J. O'Brien	x	x	x	x
27. Lenawee	P. L. Miller	Not Repres'd.			
28. Livingston	H. G. Huntington	x	x	x	x
29. Luce	F. R. Koss	Not Repres'd.			
30. Macomb	A. A. Thompson	Not Repres'd.			
31. Manistee	E. A. Oakes	x	x	x	x
32. Marquette-Alger	W. C. Lambert	Not Repres'd.			
33. Mason	C. A. Paukstis	x	x	x	x
34. Mecosta-Osceola-Lake	T. P. Treynor	x	x	x	x
35. Menominee	W. S. Jones	x	x	–	x
36. Midland	J. H. Sherk	x	x	x	x
37. Monroe	T. A. McDonald	x	x	x	x
38. Muskegon	L. E. Holly	x	x	–	–
	T. J. Kane	x	x	x	x
39. Newaygo	J. W. O'Neill	x	–	x	x
40. North Central Counties	R. C. Peckham	x	x	–	x
41. Northern Michigan	John Rodger	x	x	x	x
42. Oakland	R. H. Baker	x	x	x	x
	H. A. Furlong	x	x	x	x
	P. E. Sutton	x	x	x	x
43. Oceana	W. G. Robinson	x	x	x	–
44. Ontonagon	W. F. Strong	x	x	–	x
45. Ottawa	D. C. Bloemendaal	x	x	x	x
46. Saginaw	L. C. Harvie	x	x	x	x
	Herbert Kleekamp	x	x	x	x
47. Sanilac	N. J. Ellis	–	x	–	–
48. Shiawassee	C. L. Weston	x	x	x	x
49. St. Clair	George Waters	x	x	x	x
50. St. Joseph	R. A. Springer	x	x	x	x
51. Tuscola	L. L. Savage	x	x	x	x
52. Van Buren	W. R. Young	x	x	x	x
53. Washtenaw	P. S. Barker	x	x	x	x
	B. M. Harris	x	x	x	x
	H. H. Riecker	x	x	x	x
	C. H. Ross	x	–	–	–
54. Wayne	W. W. Babcock	x	x	x	x
	L. J. Bailey	x	x	x	x
	W. D. Barrett	x	x	x	x
	William Bromme	x	x	x	x
	W. L. Brosius	x	x	x	x
	F. G. Buesser	x	x	x	–
	C. L. Candler	x	x	–	–
	W. J. Cassidy	x	x	x	–
	M. A. Darling	x	x	x	x
	H. F. Dibble	x	x	x	x
	Douglas Donald	x	x	x	–
	B. H. Douglas	x	x	x	x
	H. B. Fenech	x	x	x	x
	L. J. Gariepy	x	–	–	–
	T. K. Gruber	x	x	x	x
	W. B. Harm	x	x	x	x
	C. K. Hasley	x	x	x	x
	L. T. Henderson	x	–	–	–
	L. W. Hull	x	x	x	x
	S. W. Insley	x	x	x	x
	R. A. Johnson	x	x	x	x
	J. A. Kasper	x	x	x	x
	E. G. Krieg	x	x	x	x
	H. J. Kullman	x	x	x	–
	C. E. Lemmon	x	x	x	x
	J. J. Lightbody	x	x	x	x
	L. J. Morand	x	x	x	x
	H. L. Morris	x	x	x	x
	R. L. Novy	x	x	x	x
	E. A. Osius	x	x	x	x
	C. I. Owen	x	x	x	x
	G. C. Penberthy	x	x	x	x
	R. H. Pino	x	x	x	x
	Lawrence Pratt	x	x	–	x
	Carl S. Ratigan	x	x	x	–
	D. C. Somers	x	x	x	–
	E. D. Spalding	x	x	x	x
	E. C. Texter	x	x	x	x
	R. V. Walker	x	x	x	x
	Arch Walls	x	x	x	x
	John E. Webster	x	x	x	x
	F. A. Weiser	x	x	x	x
55. Wexford	L. E. Showalter	x	x	x	x

(Announcements)

THE SPEAKER: I will ask the Vice Speaker to take the Chair.

(Vice Speaker R. H. Baker, M.D., Oakland, assumed the Chair)

THE VICE SPEAKER: It is now my pleasure, gentlemen, to introduce the Speaker of the House, Dr. J. S. DeTar, who will give the Speaker's Address to the House of Delegates.

II. Speaker's Address

Members of the House of Delegates:

In preparing this report, I have assumed that the framers of the Constitution of this Society placed the Speaker of the House on the Executive Committee of the Council as a representative of the House of Delegates; and that it is the duty of the Speaker to report back to

the House his impressions of the year's work between sessions.

I state very frankly that as I learned more of the work of the MSMS and of the men doing that work, I was impressed by the tremendous amount of thought and time they expended on behalf of the health and the physicians of Michigan. The Chairman of the Council, Dr. E. F. Sladek, gave seventy-one days to the work of the Society last year. The legal counsel of our Society, Mr. J. Joseph Herbert, told me recently that he has never seen an organization in which even the smallest problem is so carefully scrutinized before action is taken. You may rest assured that if the actions of the Council, and of its Executive Committee do not meet with general approval, it is not because of careless or hurried consideration.

There are several aspects of the work done by the Council and the Executive Committee on which I should *like* to report. I feel, however, that I should be remiss in my duty if I failed to report more fully the one project on which there has been the greatest amount of money expended, which has received praise and commendation from many sources outside the immediate Society, which has received some criticism within the organization, and the one subject with which I am most familiar. I refer to our educational campaign, the Public Relations effort of the Michigan State Medical Society.

All of our members have received for consideration the Public Relations Plan and two supplements detailing the newspaper and radio activity. We have had numerous legislative and public relations bulletins during the year. We have had the annual report of the Public Relations Committee, plus a supplemental report of the Council dealing with public relations activities. We have received an outline of the proposed public relations activities and budget for 1948.

I shall not repeat these reports, but should like rather to review some policies, aspects and reactions to the public relations program which may not be immediately apparent, but about which we should be informed.

There has been criticism of some of the media used. The Council of one county society has protested the use of advertising in the labor and daily newspapers in their county as a waste of funds. Criticism has been voiced of the debate topic in high schools, which was so worded as to give the proponents of socialized medicine some technical advantages. In respect to that criticism, it should in all fairness be pointed out that the Michigan State Medical Society had no voice in the selection of the topic for debate, or in the wording of the question, and that your Society made the best of the matter by supplying all available material to all schools in Michigan, and to a great many schools in other states.

There was outspoken criticism as well as enthusiastic support of the pamphlets produced in 1946. This type of pamphlet was discontinued this year. There has been no criticism in 1947.

Further, there has been expressed a marked difference of opinion as to the necessity of any public relations program at all. There are those who feel that the essence of good public relations is simply good private relations by the individual doctor (and with that we all agree), and that such privately promoted good will is sufficient (and with that many of us disagree).

Summing up the criticism, we might say that it disapproves certain of the media utilized, and to a degree involves the basic policy of the public relations effort.

This is to be expected in any organization of 4,707 members. The expressed will of the majority, as indicated in the actions taken by this House of Delegates, has been the determining factor in molding the decisions of the Council, at all times. Although you have for your analysis the reports of the Council, I should like to add these observations:

In 1945 we spent $25,923 on radio broadcasts for which we received nine sixty-minute hours on the air in twenty-eight broadcasts using one station only.

In 1946 we spent $18,156 on radio broadcasts for which we received sixteen and a quarter sixty-minute hours on the air, on sixty-six broadcasts, using sixteen stations.

In 1947, by December 31, we shall have spent $19,364 on radio broadcasts for which we shall have received three hundred and seventy-two sixty-minute hours on the air, and 3,891 broadcasts over nineteen stations. This year in return for the careful planning of our public relations counsel and an expenditure of $19,364, we will receive the equivalent value of $121,550 in air time. I repeat: for $19,000 we are getting over $120,000 in radio time. In other words, just for this year's radio program, it would have cost $136,050, had not successful arrangements been made for free time or outside sponsorship. For the "Tell me, Doctor" program alone, the Michigan State Medical Society during 1947 will have made 3,612 broadcasts. The acceptance of these programs has been excellent, by physicians and laymen alike. The Michigan State Medical Society has found a powerful voice in radio, and has effected a saving of well over a hundred thousand dollars. The 1948 Budget includes a figure of $14,500 for Radio Broadcasts—less than we have ever spent—And we anticipate an increase in number of broadcasts because of their popularity.

Legislation which was passed during the last session of the State Legislature increasing the top limits for fees for Doctors of Medicine for work done for governmental agencies will mean, in the aggregate, hundreds of thousands of dollars to the physicians in Michigan. This increase in fees was due in large part to the receptive attitude of legislators, created by the activities of our Society. Public Relations pays off in good will; but this time the results are in more tangible form. The total increment to the profession by reason of this increase in fee schedules will be greater in 1948 than the cost of the entire public relations program since its inception.

Your public relations Committee and Counsel have endeavored to economize on all fronts. In pamphlet publication, for example, the amount allocated has *not* been spent. The Michigan Society for Crippled Children and Disabled Adults, as well as the Michigan Foundation for Medical and Health Education, with the assistance of our Public Relations Counsel, have published pamphlets *at their own expense,* on subjects of definite medical public relations value, thus reducing expenditures which might have been made from our own fund. Every device has been used to obtain favorable rates in printing, mailing, and in other services, for economy. Less money was spent for office space than anticipated in the 1947 budget. The cost of our committee meetings was less than planned because some committee members did not submit bills for expenses, for which we express gratitude. The cost of the Public Relations Conference was eliminated by combining it with the Secretaries' Conference in February. We did not spend as much as anticipated in national organizations. Necessary travel expenses of the Public Relations Counsel were minimized by traveling with officers and other staff members. Unfortunate inactivity of the Michigan Health Council can enforce saving of $5,000 which was budgeted for the purpose. The total of all these savings is over $12,000.

By these and other economies we have been able to add to our original reserve of $30,000 from 1946, another $30,000 from the 1947 budget, and still cover the costs of the entire program. The Executive Committee of the Council placed this $60,000 in a special reserve for public relations emergencies. In the 1948 budget no additional reserve is planned, yet every item has been carefully reviewed and pared down to a minimum. The wisdom of holding the reserve as now set up will become apparent if Michigan is ever faced with the emergency which California fought through in 1946. In that year the California Medical Association was forced to spend $200,000 on an emergency public relations program, and is continuing its public relations

efforts on a scale even larger this year to prevent such emergencies in the future.

We have not been faced with such a legislative emergency during 1947. Whether the lull in the activities of the proponents of government-controlled medicine can be attributed to our public relations efforts is difficult to determine.

We do know, however, that large amounts of Federal money—the public's money— have gone, and are now going, into the campaign for government control of medical service. We know that persons in the Federal Security Administration have exerted, and continue to exert pressure in a well-planned long-term campaign. One need only to read the Harness report to Congress, published July 2, 1947, for substantiation. To quote one paragraph from this report:

"Suffice it at this time for your committee to report its firm conclusion on the basis of the evidence at hand, that American Communism holds this program (Socialized Medicine) as a cardinal point in its objectives; and that, in some instances, known Communists and fellow-travelers within the Federal agencies are at work diligently with Federal funds in furtherance of the Moscow party line in this regard."

I quote the words of Major General Paul R. Hawley:

"I am amazed to find how few physicians realize just how close we are to some form of socializing of medicine. They have been drugged into believing that bills before the Congress are merely the ideas of crack-pots which have no chance of ever becoming law. Nothing could be farther from the truth. Just as sure as we are together today, if medicine does not offer a workable solution to this real problem, some plan will be forced upon the medical profession."

At this session of the House of Delegates, then, we must take stock of our progress and I raise the question: shall we lessen our public relations efforts as a group, and concentrate only as individuals, or shall we maintain our efforts as an organization, and at the same time continue our efforts as individuals?

Much of our public relations effort has been directed to the end of encouraging good private relations between physician and patient, impressing upon our membership, upon each of our 4,707 members, his own responsibility in the over-all program, and supplying him with the facts on medical economic problems through pamphlets, meetings, bulletins, and the pages of THE JOURNAL.

For my part, I agree with a statement found in a report on public relations made to the Colorado State Medical Society which says in part:

"It can be said categorically that despite the vast amount of good will on the part of patients toward individual doctors, doctors *as a group* have become increasingly isolated from the rest of the community. They do not now enjoy *collectively* the respect, appreciation and understanding which are their only real bulwarks against unfavorable reactions to their profession."

I believe the Michigan public relations program is taking steps to change that situation to a more favorable one in our state. Many of these activities—on which we are spending our own money—are definitely in the public service, and are not for the economic protection of the doctor. I refer to such activities as the rural health conference, the rural health survey, the many ramifications of the Medical Plan for Michigan, about which we will hear more during this meeting. I refer to the extensive plans of the Commission on Health Care, to the work of the Michigan Foundation for Medical and Health Education. These projects are not defensive or protective in nature. They are definitely of the nature of public service.

It takes time to develop a comprehensive program. In 1946 we were mapping the way. In 1947 we have had many projects in the first stages of activity. 1948 should see tremendous progress on all fronts. We must continue our efforts as an organization in the public service—and we must let the public know what we are doing.

I have asked the President-elect to relieve me of the office of chairman of the Public Relations Committee. I have tried to report to you today, as your representative on the Council, these additional observations. Our problem today is one of policy. Your decision on the public relations program will determine whether or not we will continue as an organization, to include in our program more and more projects in the public interest, and whether we will continue to carry on a campaign of public education.

The decision of the House of Delegates in 1945 to embark on an extensive public relations program has been reflected in similar activity in many parts of the nation. Requests for our program, our literature, our techniques, have come from Colorado, Wisconsin, Virginia, Vermont, Tennessee, Pennsylvania, North Dakota, New York, Idaho, District of Columbia, and Alabama.

The newspaper editors of the state have been most gracious. Mr. Brenneman has in his files dozens of unsolicited letters from editors throughout Michigan, complimenting the Michigan State Medical Society for its works of public service and its campaign of education. Their attitude is important, for, as Dr. Clarence L. Candler said in his Wayne County inaugural address this year: "One editorial favorable to medicine is worth more than a full page ad." Mark Beltare said in the *Detroit Free Press,* "The Michigan State Medical Society is recognized as one of the most progressive in the nation."

Similar comments have come from editors of newspapers in Marshall, Sturgis, Albion, Petosky, Houghton, Traverse City, Big Rapids, Ypsilanti, Cheboygan, Cadillac, and elsewhere. Comments of this type from newswritters and editors indicate a sympathetic attitude on the part of men who are powerful molders of public opinion.

I should like to close with a quotation taken from a talk made by Dr. John W. Cline of San Francisco, the president of the California Medical Association. Speaking in January of this year, to the California physicians, about the California public relations program, his words seem particularly appropriate in Michigan. Said Dr. Cline:

"No longer can our organizations confine themselves to purely scientific matters. Our county and state societies and the AMA must necessarily make their influence felt in matters which concern public health and welfare and the practice of medicine.

"Projects such as those outlined [he was referring to the California public relations program] are necessarily expensive. During the past year the California Medical Association has expended more than *two hundred thousand dollars.* The expenditure for 1947 will be half again greater. To many this will seem to be a very large outlay, but American medicine is on the threshold of decision. The hour may be later than we think. Let it not be said that we were too niggardly to defend our freedom and the American way of life with sufficient force to prevent the advance of Socialism. If the keystone of medicine falls, the next pressure will push over the entire structure of free enterprise. We need only to look at the English experience. Compulsory Health Insurance came in 1912. Now, 1947, barely a generation later, has witnessed the complete socialization of medicine, of the Bank of England, of the railroads, of the coal mines, and of the land. We cannot afford to ignore the historical parallel. It is far wiser to do more than necessary, than too little. We should look forward to greater efforts and expenditures rather than to complacency and economy."

And now, having reported to you the situation as I see it, I wish to voice to you a pledge. As Speaker of the House, I pledge to you that from this minute I shall have no further opinion on any subject, but shall follow to the letter the advice given to me by our immediate past-Speaker and President-elect, Dr. Patrick L. Ledwidge, when he said to me at the close of the last session:

"Take no sides, be fair, and impartial, and be sure that both sides of any question have ample opportunity to voice their views."

THE SPEAKER: Now, gentlemen, it is my pleasure to introduce to you the President of our Society, Dr. William A. Hyland, of Grand Rapids.

III. President's Address

There is not very much for the President to do at this session except to welcome you. I wish to extend a welcome to this House of Delegates on behalf of Grand Rapids. By virtue of the Constitution of this Society, the House of Delegates is the governing body of this organization, and when it is not in session The Council takes its place.

You are the governing body, and your word is law. It is your duty to weigh the problems and questions that come up. As Dr. DeTar said, you have to look at things with an impartial view, and do what you think is best for medicine in general and for this Society.

The officers will be here to join in your meetings and deliberations, and we will be glad to give you any advice we can, or any explanations you may wish concerning decisions we have made during the past year. I ask you to view these questions and resolutions intelligently, and be sure you are stating matters clearly when you present them. Much time has been lost in the past by a point not having been made clear enough for all to grasp.

It reminds me of the story of the fellow sitting at the bar. A girl came in hurriedly, had four drinks in rapid succession, and then she slowed down. He wondered why she slowed down, so he said, "What's the matter? Will five make you dizzy?" She said, "The name is Daisy, but I'm interested in your proposition." That was lack of clarity in the question.

I trust you will pose your questions intelligently. I wish to thank all of you for your work last year and your work on committees. On behalf of the members of The Council may I extend congratulations to you upon your being elected again for this year. We will be at your service.

Thank you.

THE SPEAKER: By comparison that sounds like Lincoln's Gettysburg Address, doesn't it. Dr. Hyland is always clear and to the point.

The next item on the agenda is the address of the President-elect, Dr. P. L. Ledwidge, of Detroit.

IV. President-elect's Address

Your President-elect has only a few remarks to make. It is needless to say that having sat on the Executive Committee of the Council for the past six years I have had much to do with formulating and am heartily in accord with the various projects that the Michigan State Medical Society now has under way. All of these projects have been or will be discussed by the other officers at this meeting. Perhaps a few of them deserve special emphasis.

Postgraduate education certainly is one of the most important functions of this Society. For many years courses have been given in the various postgraduate centers throughout the state. On the whole these courses have been excellent and a great credit to the Committee on Postgraduate Education, under whose direction they are given. However, an occasional criticism would seem to indicate a possible demand for further expansion. I am sure that the members of the Committee on Postgraduate Education headed by our beloved past president, Dr. Howard Cummings, have the desire and the ability to make these programs satisfy every reasonable wish of our members. Let them know what you want.

Last year a new innovation in postgraduate medicine in Michigan came into being—The Michigan Postgraduate Clinical Institute. Its purpose is twofold: (1) to bring up-to-the-minute information on scientific clinical medicine to our membership; (2) to show to the world that we have in Michigan men capable of providing the very best in postgraduate medical teaching, and to train our younger men to carry on in this work. Contrary to the custom in our annual Scientific Assembly held in September each year, where most of the speakers come from outside of Michigan, every speaker for the Michigan Postgraduate Clinical Institute is a member of Michigan State Medical Society. The first meeting held in March, 1947, was an outstanding success. Plans for the 1948 Institute already are well under way. It should be made an annual event and the policy of choosing all speakers from our own membership should be perpetuated.

In last year's address as Speaker of the House, I pointed out the necessity of a public relations program, and expressed the opinion that it should be financed by a special assessment with funds collected earmarked for that purpose. Dr. DeTar has given you a detailed and illuminating report on the work done by his Committee during this past year. The need for this work still exists. The public relations program should be continued. Every councillor district and nearly every locality in the state is represented by membership on the Public Relations Committee. These men are there to advance vour interests and to express your wishes. Please let them have your help and suggestions in this necessary and difficult work.

The 1945 House of Delegates created the Commission on Health Care, with Dr. Ralph Pino as chairman. Following the chairman's report of last year, the 1946 House of Delegates instructed the Commission to continue its work. The progress report for the past twelve months is item VII on this afternoon's agenda. It no doubt will be both interesting and informative. Dr. Pino is a man of ideals and ideas. He has that imagination so necessary for advanced thinking, and in which so many of us are completely lacking. He and his Commission should have our wholehearted support until such time as all the practical possibilities of the things they are studying have been thoroughly explored.

There is considerable criticism of the Michigan Basic Science Law—criticism to the extent that some have suggested its repeal. Apparently most of the difficulty arises from the fact that the combination of the Basic Science Law and the present administrative rules of the Michigan Board of Registration in Medicine is not satisfactory. The House of Delegates recognized this unsatisfactory situation and in September, 1945, passed a resolution requesting the Board of Registration to institute remedial measures. After a careful study of the statutes and the administrative rules by our legal advisor, Mr. J. J. Herbert, the Council in January, 1946, petitioned the Board of Registration in Medicine to grant to second-year interns and hospital residents the privilege to continue their studies under proper rules and supervision without being licensed to practice medicine. The necessary changes in the administrative rules to permit of this privilege were outlined by our legal counsel and embodied in the petition.

For some reason, which has never been made clear, the members of the Board of Registration in Medicine were at that time reluctant to extend this privilege to residents. They did, however, grant it to second-year interns as of June, 1946. This action by the Board was greatly appreciated by all concerned and did much to improve a bad situation. *It is not enough.* The rules should be further liberalized to include third and fourth-year residents so that four full years of training after graduation from Medical School may be allowed prior to licensure to practice medicine.

This is not an argument either for or against changes in the Basic Science Law which would require legislative action. It could be done by a simple ruling of the Board and could be given immediate effect. It would go a long way toward correcting this nuisance that is now causing such bitter criticism. The Council plans to make this recommendation to the Board. Your endorsement of the recommendation is highly desirable.

Before closing I should like to pay tribute to President William A. Hyland. His genial personality, his gift of natural leadership, his keen interest in the science of medicine, his fine business judgment, his wide acquaintance, and his splendid ability to get things done without fuss or flurry have made him one of the most outstanding of the long list of eminent physicians who

have served as president of the Michigan State Medical Society. We owe him a debt of gratitude.

Finally I beg your most generous co-operation in next year's work. These are difficult times for medicine, and the responsibilities of your officers are heavy. To do well the things that lie before us will require the active help and the best thinking of every one of our 4,707 members.

THE SPEAKER: Thank you, Dr. Ledwidge.

The reports of the Speaker, the President-elect and the President will be referred to the Special Committee on Officers' Reports for consideration.

Next on the agenda is the annual report of The Council. Dr. E. F. Sladek, Traverse City, Chairman of The Council.

V. Annual Reports of The Council

E. F. SLADEK, M.D., (Traverse City): Mr. Speaker, the annual Report of The Council will be found in the handbook, and the supplemental report of The Council is not complete as yet.

THE SPEAKER: When Dr. Sladek is ready with the report, please inform the Speaker and we will call for it. [See page 1305.]

The next item will be the report of the Delegates to the American Medical Association, given by Dr. L. G. Christian, of Lansing.

VI. Report of Delegates to AMA House of Delegates

The delegates to the American Medical Association have continued to work in perfect accord and have attempted to carry out the instructions and suggestions of this House, and The Council of the State Medical Society.

There are two meetings each year for the delegates to attend. Supplemental meeting was held in Chicago, December, 1946. This was brought about at the suggestion of former President Roger I. Lee, because of the fact that the work of the Association has so increased that it necessitated two meetings each year. All of your delegates were present at every session of the House.

The first meeting was Monday morning, December 9, and was called to order by Dr. R. W. Fouts of Omaha, the speaker. The minutes of the proceedings of the San Francisco session were adopted. Dr. Fouts then made a few remarks and a short address, outlining the policies the speaker was to follow during our session, and followed this by appointing the various reference committees. Then Dr. Harrison H. Shoulders, president of the AMA, gave a short talk. Dr. Olin West, president-elect, was called upon, and made a few remarks. This was followed by the report of the Board of Trustees, setting forth all the activities of the Association that come under their particular jurisdiction. That report is too lengthy to repeat here, but is of vital importance.

Your delegates would like to refer you to the proceedings as printed in the *Journal of the AMA;* the report is full of meat and will show you the inner workings of your senior organization.

The secretary's report, by Dr. George F. Lull, was then read, showing an increase to 129,145 members of the AMA as of December 1, 1946. The various standing committees and councils then gave their reports, and they were all approved.

The report of the Council on Medical Service, by its chairman, Dr. E. J. McCormick, was listened to with rapt attention, as it seems to be the only organization of the AMA that is most closely watching the Washington situation. A special committee was appointed by the Speaker to study the Rich report. In the Executive Session the entire Rich report was considered section by section, and was all accepted and adopted, with the exception of that part of the report that dealt with the National Physicians' Committee. This caused quite a disturbance among the officers and delegates; however, oil was poured on the water, and no real controversies followed.

New Business: A resolution by Dr. E. V. Askey, of California, under requirements for approval of Hospitals, is of most vital importance to the medical profession of the United States, and particularly to the general practitioner. The resolution read in part:

"Resolved, That the House of Delegates of the American Medical Association suggests to the Council on Medical Education and Hospitals and directs it to further the realization of this suggestion, to wit:

"The requirements for approval of hospitals shall be so defined that there shall be (1) adequate protection of the rights of all doctors and their patients in obtaining hospitalization to the end that general practitioners as well as specialists shall have access to and use of hospital facilities; (2) that the criterion of whether a doctor may be a member of a staff or a head of a department shall be his actual ability as a doctor and not dependent on special society or board membership; (3) that the American College of Surgeons be urged to conform to these general policies in their procedures in the standardization of hospitals, and (4) that the American College of Physicians be urged to support this policy."

The resolution was sent to the Committee on Medical Education in Hospitals. The entire Michigan delegation, appeared and talked for the adoption of this resolution. I am happy to say that the committee reported favorably upon it, and it was adopted by the House of Delegates, and that the AMA, through the Council on Medical Education in Hospitals, has now written to every registered hospital in the United States, stating as their policy, that no discrimination against a general practitioner be employed.

Dr. Hamer of Indiana, introduced a resolution, calling for a convention at Atlantic City in June; this was also adopted. A resolution granting membership in the AMA to physicians employed by the Veterans Administration, those who are permanently staffed, allowed them to become members of organized medicine.

Dr. Thomas Gruber of Michigan introduced a resolution relating to general practice in approved hospitals that tied in very closely with that of Dr. Askey of California; it was passed on, and now is the policy of the AMA.

An address by Rear Admiral Joel T. Boone, on sanitary and medical conditions in the various coal mines, wasn't pretty to hear.

At the Executive Session, the House considered, paragraph by paragraph, the Rich report, as was said previously; it is practically all adopted with the exception of that portion relating to the activities of the National Physicians' Committee.

During the interval between the Chicago supplemental session and the annual session in Atlantic City, Dr. Olin West resigned as president-elect and was succeeded by Dr. Edward L. Borst of Philadelphia, the vice president.

A complete revamping of the Constitution and the By-Laws is now under way, and will be considered at the next annual meeting to be held in Cleveland.

The Atlantic City meeting of the AMA, as you all know, was the one hundredth anniversary of our senior medical society. Over 13,000 physicians registered. The formal opening of the meeting was preceded by some fifteen or twenty organizations who held their conventions during the week previous to the convening of the AMA. On Sunday before the opening of the House of Delegates, the Grass Roots Meeting was held under the auspices of the Board of Trustees. A goodly number of representatives from nearly all the states were present, and most of the boys had something to say—particularly the general practitioners—telling of their experiences back home in the difficulty in finding hospital beds for their patients. A number of the Board of Trustees were present and added impetus to the discussion. Michigan was represented by Dr. L. Fernald Foster, our secretary, who talked on the subjects under discussion and answered questions intelligently. Senator Taft was present and addressed the state presidents and other officers of the State Associations, as did Surgeon General Hawley of the Veterans Administration and General Omar Bradley. In fact, prior to the meeting, there were too

many meetings for the delegates to attend and report upon. The House of Delegates, as usual, convened on Monday morning and after the addresses of the speaker, the president and the president-elect, the report of the Board of Trustees was brought forth. After being referred to the proper reference committees, they were all adopted by acclamation and applause. Since it was the one hundredth anniversary of the AMA, all of the medical associations of the world were invited, and I understand that practically all of the nations of the world were represented with the exceptions of Germany, Russia and Japan. Dr. Morris Fishbein, in his usual suave way, introduced these various representatives—how he got by with some of the names is more than we can understand, but he did and we all applauded. Many of the distinguished foreign guests addressed the House, much of which we failed to understand.

The British Medical Society had three representatives, a president, a secretary and president-elect. The Australian Branch of the British Medical Society was represented by the president who made one of the best talks of the entire meeting. The Canadian Medical Association was represented through their secretary, who this time made a profound appeal for the success of the World Medical Society which is to meet in Paris next month. As usual, many resolutions of various types were introduced. Most of them passed. Michigan's resolution pertaining to exemption from income tax in attending medical postgraduate programs was passed and the matter referred to the Board of Trustees. We hope they may do something about it. Two Executive Sessions were held on the Rich report. It was culminated by the resignation of Mr. Swart who was the public relations man of the AMA. Mr. Swart had been hired at the suggestion of Mr. Rich. Mr. Rich later resigned. This was greeted by a lot of applause by the entire House. As previously reported, the Rich report was adopted in the Chicago session with the exception of that portion that pertained to the National Physicians' Committee. This was the bone of contention, and Mr. Rich, evidently finding the going hard, submitted his resignation after taking quite a beating. The session was the longest that had been held in the memory of your delegates. We worked from Monday morning until Thursday afternoon —early morning, afternoon, and on occasion, evening meetings. A highlight of the convention was the Delegates' Luncheon which was addressed by Secretary-of-War Patterson who gave us a rousing talk that stimulated and in some cases enthralled us all. There was not too much politics in this meeting. It seemed the delegates had pretty well made up their minds previously.

Candidates for President-Elect: S. S. Crockett of Indiana nominated R. L. Sensinich of South Bend who had served on the Board of Trustees for ten years and was the retiring chairman; Dr. Walter E. Vest of West Virginia presented the name of Dr. James R. Bloss of West Virginia. Dr. Sensinich won handily. Dr. Thomas McGoldrick of New York was elected Vice President. Dr. George Lull was re-elected Secretary. Dr. Roy W. Fouts of Omaha was re-elected Speaker of the House of Delegates. Dr. Francis Borzell of Philadelphia was elected Vice Speaker. Dr. E. J. McCormick of Toledo was elected as a member of the Board of Trustees, succeeding Dr. R. L. Sensinich of Indiana. Dr. Dwight Murray of California was re-elected to succeed himself on the Board of Trustees. First in nomination for the vacancy on the Council on Medical Service was Dr. Robert L. Novy of Detroit, then Dr. L. Howard Shriver of Cincinnati and Dr. Elmer Hess of Erie, Pennsylvania. Dr. Shriver withdrew his name from the nomination.

The business having been concluded with the exception of a place to meet in 1950, the House of Delegates chose San Francisco. Get your reservations early, by train and plane and at hotel.

THE SPEAKER: Thank you, Dr. Christian. The report will be referred to the Reference Committee on Officers' Reports.

The next item on the agenda is the report of the Commission on Health Care, which will be given by Dr. Ralph Pino, of Wayne County.

VII. Annual Report of Commission on Health Care

RALPH PINO, M.D., (Wayne): I want to supplement the report as found on page 52 in the Handbook.

I will go back a little bit, because I understand there are some who really do not know the function and the material and the plans of the Commission on Health Care.

You will recall that the purpose had to do, in the beginning, with the irregular practitioner. That is No. 1. No. 2 is completing the field of therapeutics ourselves.

I will give you just a little of our experience as we tried to study the problem of the irregular practitioner. Among the first to come before the Commission to give us advice from one angle was Dr. Madison, who is the Chairman of the Basic Science Board of Michigan and also President of the National Association of Basic Science Boards.

Briefly, we got only this far: in the minds of the members of the Basic Science Boards the whole situation is most unsatisfactory. The various states have diffierent types of setups, so an individual going from one state to another finds that the rules are different. The Boards concluded at their national meeting that there was only one answer from the standpoint of those delegated to administer this, namely, that they would have to get together and form one basic science law for all the states, in order to be able to handle the matter with any degree of satisfaction. That is the report left with us, and there was nothing more we could do about it.

In regard to the irregular practitioner, which includes all we call irregular, we had with us the attorney for the Wayne County Medical Society, Mr. Culver, also the attorney for the Michigan State Medical Society, Mr. Herbert, and Captain Potter of the Department of Law Enforcement of the State of Michigan having to do with health.

In all of the deliberations we could only conclude that there was nothing we could do about this matter under the present circumstances except to collect such data as would be applicable in the courts, and to take some of these men to court and so establish the things we feel should be established in the minds of the people and in the minds of the health professions. That is a great deal more difficult than you would imagine. As citizens of this state, we do not have access to the records of the Board of Licensure in Osteopathy.

Let us say that could be broken down. Well, when you find the person who can break it down, bring him to the Commission and he will tell us how—or would have, were it not for the fact that up to this time I think this whole problem has been taken over by The Council. A little later I will have a recommendation to submit from the Commission on this report.

The osteopaths aren't the only ones. In the discussion of the next problem with which we have tried to deal, I want to bring to your attention some things having to do with completing the field of therapeutics ourselves. I have a few slides which I want you to see. These are the things that come to the attention of the public. Everything we are dealing with here has to do with our public relations. If I say more about public relations than you feel I should, I can't be blamed, because we can't get along without them. That is what they are.

(Slide) At a recent meeting of the chiropodists in Detroit this picture was shown on the front page of the paper. Why do I call this to your attention? As I go along I want to tell you that the chiropodists are doing major surgery because we are not doing it.

(Slide) "All foot ailments treated. Complete x-ray service. Electro and hydrotherapy. Custom-built arch supports." This is public relations. These people know public relations; these people spend money on public relations. They can afford it because the people are going to them in such numbers that one has to have an

appointment a month in advance because the need of foot care is so great.

(Slide) This is on the same subject. I am not finding fault, gentlemen. We must not call names of those who are doing things we are not doing.

(Slide) "Clear-Skin Institute." Can you read it?

(Slide) Electrolysis at $250 for both legs! If there is a dermatologist in the house, do these people come to you?

(Slide) "The miracle of vision—the story with a happy ending." Contact lenses.

(Slide) "True Stories of Happy People." Contact lenses.

(Slide) Of course this fellow does not belong to our organization.

(Slide) He does this, too.

(Slide) Physiotherapy. "Nervous Disorders—Natural Methods!"

(Slide) "Dermaway University." The word "university" in the minds of 90 per cent of the people has but one meaning.

(Slide) It would be worth while to read this. It came out in the Plymouth paper. We talk about public relations! The Plymouth paper is run by one of our very excellent men in the State Senate, but the public relations practiced by these people is such that they get this: "Large X-Ray Unit Now Available Here." You might say, "We have a library now, we have an art museum, we have this and that, and behold! now we have come to the point where we have a large x-ray unit!"

"Used primarily as an aid in diagnosis"—and when I read this I remembered that it sounds all right to the individual in that town who reads it—"just recently there has been installed in the Pennyman Building offices of Dr. G. K. Ashton, chiropractic physician, a new x-ray machine. The unit is one of the largest in the country and one of the first postwar units of its type in the State. It is called a 'North American Philips,' 100-100 unit, and is capable of taking a picture of the entire spine on a 36" long negative."

At the end it says, "He invites inspection of both these new instruments at any time during his office hours."

"Another new diagnostic aid which the chiropractor has just had installed is an electric 'heartometer' which actually records the true function of the heart."

(Slide) Here is our friend Val Clare, in one of the finest brochures that has come out recently, describing and telling about a place where eyes may be straightened. This same clinic puts out pamphlets. I am not finding fault, gentlemen; I am telling you about public relations.

This clinic puts out pamphlets on the treatment of cancer by sunshine, and only when the sun shines. Another pamphlet is on the treatment of hernia without operation; another is on rectal diseases. Now they take men of public influence, such as Val Clare, who makes a statement and it comes out in something like this. This is public relations!

I said that our first project in the Commission on Health Care concerned irregular practitioners. The second is completing the field of therapeutics ourselves. I would like to call to your attention the various divisions which have to do with this subject:

Division of Dental Associates
Division of Dietetics
Division of Medical Secretaries and Librarians
Division of Nursing
Division of Clinical Laboratory Assistants
Division of Physical Medicine and Occupational Therapeutics
Division of Ophthalmic Associates
Division of Orthopedics and Dermatology
Division of X-Ray Technicians
Division of Clinical Psychology
Division of Medical and Surgical Art and Photography
Division of Associates to Hospital Administrators
Division of Economics of the Health Services
Division of Pharmacy
Division of Public Health (and Veterinarian Services)

We have added to these since then Practical Nursing, Mental Health Associates, Associates to Public Health Administrators, and we have had committees on each one of these. We have had fifteen committees, which have been made up of men of authority in these various subjects.

The Committee, let us say, having to do with Mental Care, tells us that tremendous numbers of psychologists, people who have graduated from various schools with a degree having to do with psychology, are out practicing medicine. They need to have set up associates in our medical schools so that does not have to be necessary.

These committees have worked untiringly, and except for the money that the Public Relations Committee could furnish to the Commission we could not have gotten together the volumes of material we have.

In order that you may know where the money goes, we can give you details even to postage. If they had not furnished me, as Chairman of this Commission, a full-time secretary on that job alone, we would not have had a report, that's all. We would not have been able to do very much about this. We took her from one of our best insurance companies and are paying her $275 a month. She can report to you, when it comes to the matter of what we are going to do about supporting public relations, the details of the cost.

The courses are being set up; many of them already have been set up, as you know. Nursing, for instance, already has been taken care of; laboratory technicians are taken care of; associates to the dermatologists has to be set up; associates to the orthopedic surgeons still has to be set up.

We are getting out a brochure, gotten together by these committees, which will be placed in all high schools and colleges and which will go to all the principals and vocational advisers in such schools. Let me show this to you. This is the format: "The New Field of Medical Associates. Michigan State Medical Society." It isn't entirely new, but it is new as far as the average student is concerned. They will read through this, and whereas before now they have known only of medicine and surgery or perhaps pharmacy and nursing, they can go down the list of fifteen important things in the field of medical care that they can get into.

As compared to these other things, this by the Michigan State Medical Society and the Michigan State Dental Society will go into the hands of all students who are interested in such things in this state. That means that you as doctors of medicine are talking to these students, and there is nothing more interesting or important to high school and college students than what they are going to do. Many of them are interested in the health sciences.

You know how more than once a day, over the radio, can be heard the call for nurses. People can't get them, due in part to a lack of public relations.

There will be and are a lot of things to say about it, but I shall stop talking right now, except to say that if we develop in assisting the doctor of medicine to do the things he hasn't time to do, and therefore cause patients to go to others, and supplied the number of assistants necessary, it would total about two million young people. At $200 a month it would mean a payroll of something like five billion dollars. We are paying out a lot of that already.

Let me give you a personal example: We showed a picture a few moments ago, the first one, having to do with contact lenses. A contact lens is a lens that fits under the eyelid, and it has to be put in very carefully, and must have a certain fluid that has to be just exactly right for the individual wearing it. This work is being done very largely by optometrists and others than optometrists. This coming month we will put into the course of opthalmology, in Harper Hospital, for our residents, a course in contact lens work. It will be taught by one of my associates, but we learned it from technicians and not from a doctor. The idea came originally from doctors, however.

The point is that we are going to teach that work, instead of having it done through these advertising agencies. It is just one example of doing the work ourselves or else not finding fault with others who do do it.

When an ophthalmologist sits hour upon hour and turns the lens this way or that way, and says, "Is it better this way, or this way?" that is bad economics in the distribution of medical care. True, he has to do it to begin with, but after a while that can be turned over to those who become even more expert, and then he can check on the work if he needs to, just as when a surgeon sends a patient to the hospital; he doesn't do the blood count and the urinalysis—that is taken care of by an already-set-up group of clinical laboratory technicians.

This is coming along in many of these groups, and we can give you details if you wish. It is sound from the standpoint of saving the doctor's time, sound from the standpoint of distributing more medical care. Health is always an economic asset, and it gives the opportunity of employment to a lot of people.

As to how this fits into the matter of public relations, one reason why I am talking about it is because this program needs support. Anything that distributes more medical care and brings it before people in a way they can understand is good public relations. Michigan Medical Service and Michigan Hospital Service, for example, are public services through private enterprise. That would be something the public relations people could use: public service through private enterprise.

And so we get this brochure before the students and the people. Let's not fool ourselves about this—we are not looked upon favorably at all in our schools, as far as the activities of the American Medical Association are concerned. They don't look upon its great values—they look instead at the great mistakes we have made. And while we strive here to raise money enough for public relations, the American Medical Association and various others have done great damage. The people don't understand at all why the Sister Kenny treatment should not have been examined by the medical profession.

If this subject were not as big as it is, as irregular practice and as compulsory health care, then we would not dwell upon it in this manner. If we could just remember in our public relations, as related to that statement about the Sister Kenny treatment and a lot of other things, that had the Southern and Commonwealth Utility Company gone into the Tennessee Valley (and we need to take a leaf out of that history in medicine), and had they said, "Here are great groups of people who are not getting electrical utility service, and this great valley needs flood control, and we think we can meter this stuff out of the air better than anybody else, so we will work with the government on flood control and will combine our interests," things would have been much different today. They didn't do it, and today we have a TVA which perhaps is a good thing, but the black eye that our utilities took along with private enterprise in this country—the unfavorableness of it—those companies will never live down. We are likely to go on to more and more Socialism in that direction.

The medical profession has taken a great stand in the Michigan Hospital Service and Michigan Medical Service. What did they do? It was public service through private enterprise.

Something was said here about the National Physicians' Committee. Publicly, gentlemen, that may be doing us a great deal of good; but we are here in the House of Delegates, not on the floor of our general meeting where the business of the medical profession is carried on. Gentlemen, I was one of the first to support the National Physicians' Committee, and if it can be proved to me that I ought to support it further, I will do so; but when in our public relations we put at the top of our letterheads, "Nonpolitical" when it isn't so, we are offsetting public relations. At any rate, we ought to be represented in politics and of course we are in Washington. We are dealing here with public relations.

Another thing we must know has to do with the evolution of medical care. We must realize that there is an evolution of medical care as it relates to the people. It is beginning to be thought of as a purchasable commodity, and it is beginning to be thought of in terms of the prerogative of the consumers of health care. We may think that it is the prerogative of the medical profession. We are talking about the evolution of the distribution of medical care. People are thinking of it in terms of the prerogative of the consumers, that it is the prerogative of the consumers of health care.

To try to stop the evolution of medical care in its relationship to its distribution would be like General Eisenhower issuing marching orders to General Gavin for the 82nd Airborne Division to proceed at once to surround and destroy the theory of evolution!

I am talking about the fact that we have got to do the work ourselves. It is evolving and it is going to be done.

Compare our public relations with Congress, on compulsory health insurance, with education. I have heard that comparison made entirely in the wrong way. We have to pay taxes for education. Is it compulsory? Yes, but we don't call it compulsory. Our children even have to go to school, but we don't actually say it is compulsory, although it is.

The point is this: We should do these things ourselves—the American Medical Association, instead of playing around (and I expect to have your criticism, and I will be glad to have it) with another organization, ought to be saying, "Certainly there has to be taxation, taking care of the people who need to be taken care of at government expense." We are doing exactly that now—Dr. Ainsley went down and arranged so that the veterans could be taken care of through the Michigan Medical Service. Is that compulsory health insurance? Well, that is taxation. We need to be in there talking just as loudly and helping the planners, and saying, "Certainly the doctors and the health interests have got to be paid from tax money!" That would be public relations of the first order. It doesn't have to go by the technical name "compulsory health insurance." We should be using that influence ourselves with our legislators, just as we should be doing the things shown on these slides.

Social security will never go backward; it is too late for that. Remember that, gentlemen!

I want to read something to you which relates to this whole problem of what we should be doing ourselves—the only conclusion we can agree upon. This is what the Commission could do:

"Regarding osteopathy and all other forms of irregular practice, in the interest of the people we can take but one position, that we cannot recognize other than our regular university schools of medicine and dentistry until those other schools conform to the standards of medical education as set up by the universities of this country, nor until a common Medical Practice Act requires the same evidence of fitness to practice, and therefore to licensure. To do otherwise would be to abrogate all of the principles of medical education that have been set up in safeguarding the best health interests of the people.

"Our medical schools must cover the fields of recognized therapeutic procedure by putting in all such courses such as physical medicine and occupational therapeutics, and whenever claims for new procedures arise from any source they must be referred to the Research Department of the division of the medical school concerned, instead of just saying 'There is nothing to that' if we are going to foster our public relations.

"When we are able to say this happens—when we are able to say that this or that has been tried out and worked upon in our medical schools—we will have an answer with no accompanying apology. Our public

relations must be sufficiently positive, and termed in such language, that it can be and will be understood by all members of the medical profession and by the people as relating to our stand on irregular practice."

If we can't go before the legislators of this state or of any other state and say, "This is our stand in the interests of the people," then we are just weaker than the other groups. We are going to continue to be weaker than the other groups if we do not support our public relations men.

I wish something personal might be said here for the man in charge of public relations, who has helped us so much in all of this material. Other organizations are trying to get him away from us at vastly greater salary. From my experience with medical societies I want to say to you that the officers we elect to this Society, if not given the help of such men, cannot do that which you expect them to do. From the standpoint of this Commission, and going into some of these very gutter-like things we have had to study, let us not vote for less than $25 each in the matter of public relations.

THE SPEAKER: This report will be referred to the Reference Committee on Special Committees.

SPECIAL MEMBERSHIPS

All requests for Special Membersbips received by tbe secretary have been referred to the Reference Committee on Special Memberships.

We will proceed to the matter of resolutions. Are tbere any resolutions to come before the House at this time? If so, will you kindly state your name and county and step forward. All resolutions must be presented in triplicate.

VIII. Resolutions

VIII—a. RH FACTOR DETERMINATION BY STATE HEALTH DEPARTMENT

H. W. WILEY, M.D. (Ingbam):

"WHEREAS, the State Department of Health Laboratories has been rendering a valuable and continuing service to the people and physicians of Michigan in testing blood for Rh factor and Rb titer determinations, and

"WHEREAS, it is the unanimous opinion of the medical profession tbat these determinations are very important in cases of expectant mothers, newborn infants and in all transfusions; therefore, be it

"RESOLVED: Tbat it is the urgent desire of this Society that this service be continued to the people and to the physicians of Michigan; and be it further

"RESOLVED: That the Ingham County Medical Society instruct its delegates to take this resolution to the meeting of tbe House of Delegates of the Michigan State Medical Society in Grand Rapids, September 21-23, and urge its adoption."

This resolution was passed unanimously by the Ingham County Medical Society at their meeting last Tuesday night, and is signed by the members present. I urge its adoption.

THE SPEAKER: Thank you, Dr. Wiley. This resolution will be referred to tbe Reference Committee on Resolutions.

VIII—b. NEW SECTION ON NERVOUS AND MENTAL DISEASES

T. K. GRUBER, M.D. (Wayne): First I have a resolution that comes from the Society of Neurology and Psycbiatry. I happen to be a member of this organization, and the Society would like to present this resolution.

"WHEREAS, the Michigan State Medical Society has recognized and approved ten specialty sections with scheduled meetings at the time of the annual meeting of the entire Society, to wit: General Practice, Surgery, Internal Medicine, Gynecology and Obstetrics, Pediatrics, Anesthesia and Pathology, Radiology, Dermatology and Syphilology, Ophthalmology and Otolaryngology, and Urology, and

"WHEREAS, mental health problems are making increasing demands upon the medical resources of state and nation in imperative manner; this is partially reflected in the observation that the average daily patient census of the twenty Michigan hospitals and institutions for the mentally ill is greater than the average daily patient census of the 183 Michigan general hospitals, as 26,884 is to 24,872, and

"WHEREAS, mental health is a specialty separate and distinct from those mentioned, and since there has not been established a Section on Nervous and Mental Diseases of the Michigan State Medical Society, and

"WHEREAS, such a Section is active and beneficial to the membership of the American Medical Association and many other national associations and state medical societies, and

"WHEREAS, such a Section would be mutually advantageous both to the specialists in mental health and to the physicians in general practice and in the various other specialties; therefore, be it

"RESOLVED: That a Section on Nervous and Mental Diseases be established in the Scientific Assembly of the Michigan State Medical Society."

THE SPEAKER: Tbis resolution will be referred to the Reference Committee on Constitution and By-Laws.

IX. Amendments to Constitution and By-Laws

IX—a. PROPOSED GENERAL REVISION OF CONSTITUTION

T. K. GRUBER, M.D.: Please turn to page 111 of your Handbook, Constitution and By-Laws.

Some time during the early part of the year The Council of your Society deemed it advisable to study the Constitution and By-Laws of the State Medical Society. Many organizations in the past few years have realized that their constitutions and by-laws needed to be rather streamlined and brought up to date.

This organization is eighty-two years old. I believe if you will read the Constitution, particularly, you will find that it has been added to from time to time, and I believe you will agree with me that there are many things in the Constitution which belong in the By-Laws.

Accordingly, a committee was appointed to make a study of this, which committee included Mr. Herbert as an advisory member, Dr. DeTar, Dr. Holmes, Dr. Ledwidge, and myself as Chairman.

We bave made a study of the situation. In 1946 the American Medical Association decided to revise its Constitution and By-Laws. They started it in San Francisco. The matter was brougbt to the attention of the House of Delegates in Chicago last year. A revised draft was presented to the House of Delegates of the American Medical Association at Atlantic City. It will be considered again at the January meeting in Cleveland, and we hope it will be ready for final adoption at the annual meeting next June.

When we go into the proposition of revising our Constitution and By-Laws we realize they must be brought up together so that the whole thing will go through at one time. If we were to try to revise the Constitution without revising the By-Laws we would have a hodgepodge.

Last evening The Council moved to request me to present to this House of Delegates the proposed amendments that this Committee has suggested, as embodied in the report to The Council, and to present a resolution that the President be authorized by the House of Delegates to appoint a committee to study and to prepare amendments to the Constitution and By-Laws during the ensuing year, and to report at the next meeting of the House of Delegates.

Accordingly, I am presenting proposed amendments to the Constitution at this time.

(See Appendix A, December issue).

T. K. GRUBER, M.D.: I present these at this time so that they can come up for consideration next year.

I move, Mr. Speaker, that a committee be appointed by the President to study and report on a revision of the Constitution and By-Laws at the next annual meeting.

E. D. SPALDING, M.D. (Wayne): I support the motion.

THE SPEAKER: According to the Constitution, these amendments must lie over for one year. The motion is that a committee be appointed to study and report back next year the amendments to the Constitution which have been read.

(Tbe motion was put to a vote and was carried unanimously).

THE SPEAKER: The resolution, motion, and the proposed amendments will be referred to the Reference Committee on Revision of the Constitution and By-Laws.

VIII—c. ON JOURNAL MSMS

C. I. OWEN, M.D. (Wayne):

"WHEREAS, the Michigan State Medical Society is one of tbe largest component state medical society units of the American Medical Association, and

"WHEREAS, there is considerable scientific medical work carried on in the State of Michigan at all times, and

"WHEREAS, if the Michigan State Medical Society had a first-class, up-to-date JOURNAL with an aggressive scientific attitude it would be able to obtain an almost unlimited number of original articles from its own members, and

"WHEREAS, the quality of most of the scientific papers published in the MICHIGAN STATE MEDICAL SOCIETY JOURNAL are of a rather low level, consisting to a great extent of a re-hash of literature, and

"WHEREAS, some of the state medical society journals (e.g., the *New England Medical Journal*) in this country are of a very high caliber, and publish considerable scientific work and numerous original articles; therefore, be it

"RESOLVEN: By the House of Delegates of the Michigan State Medical Society, at its meeting in 1947 in Grand Rapids, that aggressive action be taken by the Editorial Board and the business management of the Journal of the Michigan State Medical Society, to place THE JOURNAL in a position where the members who are doing high-grade scientific work will compete for space to publish their articles in THE JOURNAL; and be it further

"RESOLVEN: That there be no delay in the adoption of this new policy."

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions.

VIII—d. ON SPECIAL ASSESSMENT ($25.00)

R. L. NOVY, M.D. (Wayne): On behalf of the delegates from Wayne County I am presenting this resolution:

"WHEREAS, the standing of the medical profession demands a strong medical organization, and

"WHEREAS, a strong organization is dependent upon its financial ability to meet situations as they arise, and

"WHEREAS, we of Wayne County are fully aware of the need for a strong, well-armed medical organization; therefore be it

"RESOLVED: That an assessment of $25 for the year 1948 be levied, the same to be utilized at the discretion of the Council, in whom we have every confidence."

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions.

IX—b. AMENDMENTS TO CONSTITUTION PROPOSED IN 1946

There are some proposed amendments to the Constitution which have lain over from last year. They will be referred automatically to the Reference Committee on Amendments to the Constitution and By-Laws by the Secretary.

1. Re Life Membership:

WHEREAS, Article III, Section 8 of the Constitution of the Michigan State Medical Society, re "Life Members" does not adequately serve the best interests of the Michigan State Medical Society and does not confer upon its members the honor intended; therefore be it

RESOLVED, That Section 8 of Article III, of the Michigan State Medical Society Constitution be deleted.

2. Re Life Membership:

WHEREAS, Section 8 of Article III of the Constitution is originally intended to recognize period of service and membership in the Michigan State Medical Society and

WHEREAS, Section 6 requires fifty years in the practice of medicine regardless of attained age of the individual, and

WHEREAS, Ten years of membership regardless of age, is a relatively short period of membership, therefore be it

RESOLVED, That Section 8 of Article III be amended to read: "A physician who has attained the age of seventy years or more and maintained an active membership in good standing for twenty-five years or more."

3. Re Emeritus Membership:

Amend Article III, Section 6, as follows:

Emeritus Membership—Any physician who has been in practice fifty years, or has attained the age of seventy years, and who has maintained a membership in good standing for twenty-five years, may, upon written application and upon recommendation of his county society, and by election in the House of Delegates, become a member emeritus. A member emeritus shall be required to pay annual dues to the State Society not in excess of ten dollars and be relieved of paying all assessments. He shall be entitled to all the benefits and privileges of membership.

Delete Section 8 of Article III, which deals with life membership.

4. Re Life Membership:

Amend Article III, Section 8, as follows:

Life Members—A physician who has attained the age of seventy years or more and maintained an active membership in good standing for twenty-five years or more in the State Society may, upon his signed application, filed in the office of the State Society, and approved by his county Society at a regular or special meeting thereof, be transferred to the Life Members' Roster by election in the House of Delegates. He shall have the right to vote and hold office but shall pay no dues to the State Society. Requests for transfer shall be accompanied by certification by the Secretary of the State Society as to years of membership in good standing.

VIII—e. FORMS OF MEDICAL PUBLIC RELATIONS

E. G. KRIEG, M.D. (Wayne): I wish to present the following resolution:

"WHEREAS, we recognize that the status of public relations has become an important aspect of medical practice, and

"WHEREAS, we realize that an adequate educative program can no longer be directed intelligently by the individual physician, and

"WHEREAS, it is extremely important to keep the tenure of such a program consistent with the dignity of time-honored relations between the patient and the physician, and

"WHEREAS, we find it extremely difficult and at times impossible to discuss 'Joe Genius' and the IDWTGTRMB Club at the same level with intimate medical care; therefore, be it

"RESOLVEN: That the Public Relations Committee be instructed to eliminate any and all such forms of adolescent approach to the public."

THE SPEAKER: This will be referred to the Reference Committee on Resolutions.

VIII—f. EXPENDITURES IN U. S. EXECUTIVE DEPARTMENTS

R. S. MORRISH, M.D. (Genesee):

"WHEREAS, House Report 786, 80th Congress, entitled 'Investigation of the Participation of Federal Officials in the Formation and Operation of Health Workshops' shows evidence that there have been violations of Section 201 of Title 18 of the United States Code by employes of the departments and agencies specifically mentioned in the report, and

"WHEREAS, it was suggested and recommended by the Subcommittee on Publicity and Propaganda of the Committee on Expenditures in the Executive Departments that 'action be taken by the Attorney General of the United States to prosecute these violations, and to prevent further disregard by federal employes and agencies of the law cited'; therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society does approve of the purpose of the investigations made by the Subcommittee on Publicity and Propaganda of the Committee on Expenditures in the Executive Departments, and does commend its fearless presentation of evidence uncovered during its investigation, and does hereby urge the Attorney General of the United States to give careful consideration to the recommendation of this Committee, and that the Subcommittee be advised of the action of the House of Delegates by sending a copy of this resolution to its Chairman, The Honorable Forest A. Harness, of Indiana; and be it further

"RESOLVEN: That additional copies of this resolution be sent to the Speaker of the House of Representatives, the Honorable Joseph W. Martin, Jr., Washington, D. C., and also to the Chairman of the Committee on Expenditures in the Executive Departments, the Honorable Clare E. Hoffman of Michigan, and to the Attorney General of the United States, the Honorable Tom C. Clark."

THE SPEAKER: This resolution will be referred to the Reference Committee on Officers' Reports.

VIII—g. RATIO OF MEDICAL OFFICERS IN THE ARMED FORCES

B. M. HARRIS, M.D. (Washtenaw):

"WHEREAS, the Army and Navy demand 6.5 physicians per 1,000 personnel (i.e., 1 per 154 men) in peace and war, and

"WHEREAS, during World War II in the Navy and Marine Corps 3.7 physicians per 1,000 personnel were actually recruited, even this ratio being too high, and in the Army there were about 4 per 1,000 personnel, and

"WHEREAS, during the same period the ratio of physicians to the civilian population was reduced to about 1 to 1,750 thus giving the armed services approximately seven times as many physicians per 1,000 as the civilian population, and

"WHEREAS, it is the opinion of a majority of civilian physicians who served in the armed forces that an excess of medical officers was present, resulting in a serious waste of medical manpower; therefore be it

"RESOLVED: That since these ratios are determined by law, the House of Delegates of the Michigan State Medical Society instruct the Council to contact, in the most effective manner, the Representatives and Senators of the State of Michigan in the federal Congress, urging them to initiate and support legislation reducing the ratio of military surgeons to 3 per 1,000 (i.e., 1 to 333)

for all services except the Air Force. This is approximately twice the ratio achieved in the civilian population in peacetime. And be it further

"RESOLVED: That the Council be instructed to contact all other state societies and the American Medical Association, urging these bodies to take similar action."

THE SPEAKER: This resolution will be referred to the Reference Committee on Reports of the Council.

VIII—h. ON MHS RECOGNITION OF CERTAIN HOSPITALS

J. E. LIVESAY, M.D. (Genesee):

"WHEREAS, the Michigan Hospital Service was created with the aid and approval of the doctors of medicine of the State of Michigan, and

"WHEREAS, the intimate association of the Michigan Hospital Service and the Michigan Medical Service has created the belief among the people of this State that they act for and with the consent of the doctors of medicine of Michigan, and

"WHEREAS, the Board of Directors of the Michigan Hospital Service are now recognizing certain sub-standard hospitals as participating in the Michigan Hospital Service plan, and

"WHEREAS, these sub-standard hospitals are not staffed by regularly registered doctors of medicine, and

"WHEREAS, the Michigan Hospital Service was organized to give the public a high-quality hospital care during time of illness; therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society does regret, and protests the action of the Board of Directors of the Michigan Hospital Service in recognizing those sub-standard hospitals, and requests that it reconsider its action with the view of discontinuing such recognition."

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions.

VIII—i. ON MMS FEES TO OTHERS THAN DOCTORS OF MEDICINE

J. E. LIVESAY, M.D.:

"WHEREAS, the Michigan Medical Service was created by the doctors of the State of Michigan and was licensed under a special enabling act for the purpose of offering a high quality prepaid medical service to the people of the State of Michigan, and

"WHEREAS, that quality of medical service is being endangered by the recognition and payment of fees to practitioners other than doctors of medicine, and

"WHEREAS, the enabling act No. 108, Public Acts of 1939, Section 12, paragraph 2, states, 'A non-profit medical care corporation shall not furnish medical care otherwise than through doctors of medicine, licensed and regulated under Act 237 of the Public Acts of 1899, as amended (6737-67-47),' and

"WHEREAS, the legality of such payments has never been passed upon by the Michigan Supreme Court; therefore, be it

"RESOLVED: That the elected and appointed officers of Michigan Medical Service be instructed to conform to the letter and spirit of the Enabling Act."

THE SPEAKER: This will be referred to the Reference Committee on Resolutions.

VIII—j. ON MMS ENABLING ACT

J. E. LIVESAY, M.D.:

"WHEREAS, Michigan Medical Service was created by the doctors of Michigan for the purpose of supplying the best in prepayment medical service, and

"WHEREAS, certain members of the Board of Directors of Michigan Medical Service have appeared before the Council of the Michigan State Medical Society advocating a change in the Enabling Act permitting the recognition and payment of fees to practitioners other than doctors of medicine, and

"WHEREAS, such a change is contrary to the content and spirit of the Enabling Act and contrary to the best interests of the medical welfare of the people of this State; therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society states as its established policy that the Enabling Act as now constituted, without any change at this time, will best serve the medical welfare of the people of the State of Michigan, and hereby directs its officers and representatives on the Board of Directors of Michigan Medical Service to act accordingly."

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions.

VIII—k. ON NEW SECTION OF PUBLIC HEALTH AND PREVENTIVE MEDICINE

G. C. STUCKY, M.D. (Eaton): This is a resolution presented by Dr. Douglas of Detroit and myself:

"WHEREAS, public health and preventive medicine has become a well-recognized field of special attention in medical practice, in which organized medicine has had a great interest and has contributed to its development, and

"WHEREAS, there are now many members of the Michigan State Medical Society who are engaged in full-time or part-time service in the field of public health and preventive medicine, and

"WHEREAS, it is believed that closer relations on the part of those in public health and preventive medicine and those physicians engaged in this field of medical practice would be in the best interest of the public and the profession; therefore, be it

"RESOLVED: That this House of Delegates recommend to The Council of the Michigan State Medical Society that a Section, to be known as the Section on Public Health and Preventive Medicine, be established."

THE SPEAKER: This resolution will be referred to the Reference Committee on Amendments to the Constitution and By-Laws.

VIII—l. ON MICHIGAN HIGH SCHOOL ATHLETIC ACCIDENT BENEFIT FUND

B. H. DOUGLAS, M.D. (Wayne): This resolution is presented on behalf of the Wayne delegation:

"WHEREAS, members of the Michigan State Medical Society have been circularized by the Michigan High School Athletic Accident Benefit Fund with a fee schedule at variance from the fee schedule of the Uniform Fee Schedule for Governmental Agencies, and

"WHEREAS, the annual report of the Committee on Michigan High School Athletic Accident Benefit Fund, 1946-47, of the Michigan State Medical Society, recommends that this plan 'can be done on a local scale to a better advantage than recommending that uniform procedures be followed in a county'; therefore, be it

"RESOLVED: That the report of this Committee be accepted, that its recommendation be followed at the local level, and that the Committee be discharged."

THE SPEAKER: This resolution will be referred to the Reference Committee on Special Committees.

VIII—M. ON TENURE OF STATE HEALTH COMMISSIONER

D. C. BLOEMENDAAL, M.D. (Ottawa): This is a request from the Ottawa County Medical Society:

"The Ottawa County Medical Society, at its regular meeting on Friday, September 19, 1947, at Grand Haven, adopted the following resolution:

"WHEREAS, the members of the Ottawa County Medical Society find the work of Dr. William DeKleine satisfactory as State Health Officer, and believe that Dr. William DeKleine will be amply able to work out the perplexing problems of the future as he has those of the past; be it

"RESOLVED: That the members of the Ottawa County Medical Society favor the continuance of Dr. William DeKleine as State Health Officer; and be it further

"RESOLVED: That the delegate of the Ottawa County Medical Society be instructed to convey these sentiments to the House of Delegates convened at Grand Rapids, September 21-23, 1947."

THE SPEAKER: This resolution will be referred to the Reference Committee on Reports of the Council.

Are there any other delegates who have resolutions? If there are none at the present, is Dr. Sladek ready with the supplemental report of The Council?

V. Annual Reports of The Council

E. F. SLADEK, M.D.: Members of the House of Delegates, this is the supplemental report of the Council:

The Annual Report of The Council for the year 1946-47 appears in the Handbook for Delegates beginning at Page 37. As this report was written July 12 in order that it might appear in print, The Council wishes to submit additional information on matters which it has considered during the past few months.

1. *Membership*—The membership of the Michigan State Medical Society as of September 15, 1947, totals 4,707, including 304 military and special members who are relieved from paying dues and assessments.

(Incidentally eighty-six special memberships were granted last year, and seventy-seven are being sought at this session of the House of Delegates which represents a loss of income of $6,031, annually.)

2. *Finances*—The Constitution of the Michigan State Medical Society charges The Council with administration of the funds of the Society, and the Treasurer with responsibility for safekeeping of the Society's invested funds.

Following the mandate of the Constitution, The Council has caused an "annual audit to be made of the funds of the Society by a certified public accountant." The report of Ernst & Ernst, for the year 1946, was published in the March, 1947, issue of THE JOURNAL MSMS, beginning at Page 339. On the same page is a copy of the Budgets of the Society for the year 1947. The audit of Ernst & Ernst is and always has been open for inspection by any member of the Michigan State Medical Society who may call at the Executive Office, 2020 Olds Tower, Lansing.

Report of our auditor for the first eight months of 1947 (to September 1, 1947) of income, expense, and accounts receivable is as follows:

INCOME AND ACCOUNTS RECEIVABLE

January 1, 1947, to September 1, 1947		
Society Dues	$ 45,680.02	
Journal Subscriptions (allocation from dues)	6,525.70	
Public Education Fund ($25. assessment)	108,792.03	
Advertising, Reprints and Cuts	29,990.91	
Annual Session Income	14,840.00	
Postgraduate Clinical Institute	5,040.00	
Rheumatic Fever Fund	14,537.26	
Interest and Miscellaneous Income	519.64	
Total Income and Accounts Receivable 9/1/47		$225,925.56

EXPENSES TO SEPTEMBER 1, 1947

Administration and General	$ 17,319.75	
Society Expense	2,944.28	
Committee Expense	7,159.96	
Public Education Expense	49,183.88	
Journal Expense	25,348.03	
Annual Session Expense	4,314.25	
Postgraduate Clinical Institute	4,928.46	
Rheumatic Fever Expense	3,955.73	
Total Expenses to 9/1/47		$115,154.34
Balance Cash and Accounts Receivable		$110,771.22

* * * * *

BOND ACCOUNT

(a) General Bond Account:			
Canadian Pacific Railroad Company	$ 2,000.00		
Detroit Edison Company	2,000.00		
Grand Rapids Affiliated Corporation	1,000.00		
New York Central Railroad Company	2,000.00		
United Light and Power Company	1,000.00		
Southern Pacific Company	1,000.00	$ 9,000.00	
(b) Bonds earmarked for Public Education:			
United States Savings Bonds, Series G	$63,600.00		
United States Savings Bonds, Series D	1,300.00		
United States Savings Bonds, Series F	3,700.00		
United States Treasury 2½% Bonds	8,000.00	$76,600.00	$85,600.00

3. *Public Education Account*—This fund, accumulated from the special $25.00 assessment levied by the 1946 MSMS House of Delegates, has been kept separate from the other accounts of the Michigan State Medical Society and has been used exclusively for public relations and public education purposes, as indicated in the following accounting:

PUBLIC EDUCATION ACCOUNT

Financial Report—January 1 to September 1, 1947

INCOME		
Balance on Hand January 1, 1947 (Includes $30,000 in Bonds)	$ 43,614.02	
Check to Michigan Health Council Cancelled	5,000.00	
Income in 1947	108,792.03*	$157,406.05

*Including $1,300 prepaid in 1946.

DISBURSEMENTS		
Salaries	$ 5,853.39	
Rent and Light	39.45	
Telephone and Telegraph	489.07	
Printing, Stationery and Supplies	537.20	
Postage	503.21	
Equipment	374.77	
Travel Expense	1,523.52	
Public Relations and Sec. Conference	2,535.05	
Purchase of Pamphlets	1,318.60	
Radio	13,972.15	
Newspaper	21,157.04	
Rural Health Conference	200.68	
Conference of Presidents	50.00	
Committee Meetings	303.88	
Miscellaneous	325.87	$ 49,183.88
Balance as of September 1, 1947		$108,222.17
Surplus ($30,000 in bonds and $30,000 in savings)		60,000.00
		$ 48,222.17
Estimated and Contracted Expenditures to December 31, 1947		$ 33,802.40
Estimated unexpended funds available as of December 21, 1947		$ 14,419.77

Most of the unspent balance—not including the reserve set up by The Council—has been allocated to various public relations and public education projects as per the Public Relations budget for 1947.

Estimates of the probable expenditures for the 1948 Public Relations and Public Education program of the Michigan State Medical Society, as projected by the Public Relations Committee and approved by The Council, are as follows:

ESTIMATED PUBLIC RELATIONS EXPENDITURES FOR 1948

I. Administrative Expense		
Salaries		$ 12,150.00
Office, rent and light		520.00
Printing, stationery and supplies		1,200.00
Equipment		200.00
Postage		1,200.00
Telephone		800.00
Travel		2,000.00
II. Radio		
"Tell me, Doctor"		14,500.00
Other radio programs		1,000.00
III. Newspapers		
Advertising		15,000.00
News Releases and Health Column		6,000.00
IV. Cinema		
Four Films		48,000.00
V. Publications		
Medical Plan for Michigan		5,000.00
Medical Associates		7,000.00
Other pamphlets		6,000.00
VI. Display		2,000.00
VII. Organizational		
Committee Meetings		1,000.00
National		200.00
State		4,000.00
VIII. Schools		
Sex Education		500.00
Libraries		500.00
IX. Other Activities		
Annual Public Report		3,000.00
Preparatory work (information on MSMS members)		1,000.00
Library		1,000.00
Checking service		100.00
Photographic service		500.00
TOTAL		$134,370.00

4. *Information to the public.*—Responsible health commentators in Washington advise that 1948 undoubtedly will be a "health" legislation year. They inform us that the choice of the medical profession must be either the Taft Health Bill or the Wagner-Murray-Dingell Bill—the decision resting on the activity of all doctors of medicine in the United States. Personal influence with individual legislators cannot be depended upon to win the battle. The decision will be reached by the people who are in the process of making their choice *NOW!* Today, therefore, organized medicine is forced to carry a far greater load in public relations and information to the people than the heavy burden it shouldered in the past two years. Postwar confusion still reigns in legislative circles. The possibility of sudden unwise legislative action is a serious threat which must be fully realized

by the medical profession. We must make ready to use all counter offensives that have been developed.

The progressive public relations program of the Michigan State Medical Society is our best weapon; it must be made ever stronger; it must be financed.

Every doctor and every person in Michigan repeatedly must be told the facts about quality medical service, its wider distribution and American ways of meeting its cost. An example of how this was dramatically and effectively accomplished with the rural group is the recent Michigan Rural Health Conference sponsored by the Michigan State Medical Society and held last week on the campus of Michigan State College.

The medical profession must continue its fight to preserve the private practice of medicine, as we know it, in the interests of the people we serve. We must remember that no organization will fight this fight for medical practitioners in this state other than the Michigan State Medical Society and its components. *A recommendation on this subject follows.*

(This has been focused most clearly in the just-released Colorado State Medical Association report on its public relations needs and program—a survey costing $25,000 which embodies recommendations for public relations work that Michigan has been doing for two years—without such a costly study.)

5. *Professional Relations.* (The Council Chairman ad libbed briefly on this subject.)

6. *Study of Medical Practice Act in Michigan.*—During the past year, the MSMS Council appointed a special committee to Study the Medical Practice Act of Michigan headed by H. L. Morris, M.D., Detroit. This Committee's study is not complete and The Council has authorized a continuation of the Committee's very important work.

7. *Revised Uniform Fee Schedule for Governmental Agencies.*—Copies of this revised Uniform Fee Schedule for Governmental Agencies have been supplied to all members of the House of Delegates and will be mailed to all other members of the Michigan State Medical Society next week. This revision, approved by the U. S. Veterans Administration and by Michigan Medical Service in July, 1947, is worthy of adoption by all governmental units, including cities and counties charged with the responsibility of furnishing medical care to their wards. The MSMS Council again invites attention to the third recommendation made in its original report "urging all component, district and county medical societies to make every effort, within the next few months, to negotiate necessary revisions in Schedules of Benefits covering governmental wards so that individual members of county societies are not penalized by being forced to perform services at a financial loss."

8. *Michigan Medical Service.*—An up-to-date report on this corporation, including finances, will be presented to you at the meeting of Michigan Medical Service membership tomorrow (Monday, September 22, at 2:00 p.m.) in this room. All MSMS Delegates are members of the Michigan Medical Service Corporation.

9. *Michigan Hospital Service.*—A special committee of The Council is working on the Michigan Hospital Service-Mercy Hospitals situation; discussions are continuing and various points are being brought out. Progress is being made.

10. *Honoring General Practitioners.*—Six years ago, your delegates to the AMA introduced a resolution requesting the creation of a Section on General Practice. They were supported by only one other state. Two years ago such a section was established, as a direct result of the continued efforts of your hard-working delegates. Now the American Medical Association has picked up the banner of the general practitioner to the extent that the coming midwinter session of the House of Delegates of the AMA will be held in conjunction with a scientific meeting designed particularly for the general practitioner. In addition, the Board of Trustees of the AMA has established a special gold medal award for a general practitioner who has rendered exceptional service to his community. Nominations for this award may be submitted to the headquarters office in Chicago by any state medical society or any community service club.

Surely, somehere in Michigan, there exists a general practitioner eminently worthy of this high honor, not only because of the superior quality of medical service which he has rendered to his community, but also because of his humaneness, his interest in his people, and his interest and leadership in all civic affairs.

A recommendation on this subject follows.

11. *Academy of General Practice.*—The Council has given consideration to the Academy of General Practice and urges the creation of local units in Michigan. The development of a state organization would enhance the activity of the National Academy.

12. *Michigan Rural Health Conference.*—Elsewhere in this report, the first annual Michigan Rural Health Conference of September 18-19, 1947, chairmanned by H. B. Zemmer, M.D., Lapeer, was mentioned. This very successful experiment in public relations with our Michigan rural groups brought out three important recommendations, as follows:

1. Authority to set up a committee to arrange for a second rural health conference in 1948, and to assume responsibility implementing the resolutions already passed by this conference.
2. Authority to set up a committee to investigate a students' medical scholarship fund.
3. Authority to set up a committee to plan and assist in the organization of local health councils in rural areas, with the approval of the county medical society.

RECOMMENDATIONS

We respectfully invite to your attention the five recommendations in the original report of The Council which are printed on Pages 50-51 of the Handbook for Delegates.

In addition, The Council recommends:

1. That the House of Delegates authorize the continuation of the progressive public relations and public education program of the Michigan State Medical Society, as effectively carried out in 1947, and that it finance this important and necessary project by a per capita membership assessment of $25.00 for the year 1948.

2. That the House of Delegates consider the granting of Life Memberships to Doctors of Medicine who have attained the age of seventy years and who have been members of the Michigan State Medical Society for a period of twenty-five consecutive years or more.

3. That the membership of this House of Delegates take back to their county societies the information regarding the AMA gold medal award for an outstanding general practitioner, that efforts be made to locate the Michigan candidates for this award, and that nominations, together with complete substantiating data, be submitted to the Executive Committee of The Council before its November meeting, so that a Michigan candidate or candidates may be selected for submission to the headquarters of the AMA.

Respectfully submitted,

E. F. Sladek, M.D., *Chairman*
O. O. Beck, M.D., *Vice Chairman*
L. F. Foster, M.D., *Secretary*
C. E. Umphrey, M.D.
P. A. Riley, M.D.
Wilfrid Haughey, M.D.
R. J. Hubbell, M.D.
J. D. Miller, M.D.
R. C. Pochert, M.D.
T. E. DeGurse, M.D.
W. E. Barstow, M.D.
F. H. Drummond, M.D.
R. H. Holmes, M.D.
A. H. Miller, M.D.
W. H. Huron, M.D.
D. W. Myers, M.D.
E. R. Witwer, M.D.
J. S. DeTar, M.D.
W. A. Hyland, M.D.
P. L. Ledwidge, M.D.
A. S. Brunk, M.D.

THE SPEAKER: Thank you, Dr. Sladek. I should like to point out that some parts of this report, particularly those objections to the type of medical practice found in some localities, have their only way of getting to the membership of our Society through us who are here today.

This report will be referred to the Reference Committee on Reports of The Council.

I should like to read a telgram just received: "The Michigan State Dental Society extends sincere greetings to the Michigan State Medical Society at your 82nd annual meeting. May your deliberations continue the progress made through the years by your Society toward better health for the people of our state. (Signed) Charles H. Jameson, D.D.S., President, Michigan State Dental Society."

X. Reports of Standing Committees

The next order of business is the supplemental reports of standing committees. I should like to point out that the reports of standing committees of the Society are found on pages 55 through 93. The Chair will read the names of the standing committees. If there are supplemental reports to be given by various chairmen or representatives of the standing committees, will those delegates please come to the front seats.

As I read the names of the standing committees, if there are no supplemental reports, the reports will be considered as published in the Handbook and will be referred to the Reference Committee on Standing Committees.

Is there any supplemental report from:

X—a. LEGISLATIVE COMMITTEE
X—b. COMMITTEE ON DISTRIBUTION OF MEDICAL CARE
X—c. MEDICAL LEGAL COMMITTEE
X—d. PREVENTIVE MEDICINE COMMITTEE
X—e. CANCER CONTROL COMMITTEE
X—f. MATERNAL HEALTH COMMITTEE
X—g. VENEREAL DISEASE CONTROL COMMITTEE
X—h. TUBERCULOSIS CONTROL COMMITTEE
X—i. INDUSTRIAL HEALTH COMMITTEE.
X—j. MENTAL HYGIENE COMMITTEE

H. A. LUCE, M.D.: I have been importuned by the other members of the Committee that perhaps it would not be a bad idea to explain a little bit about our report. There were certain things we would like to have incorporated in the report, but we were not able to do so.

Please turn to page 73, paragraph 2. A great deal of emphasis has been placed on psychiatry, especially as a result of the war. Your Committee feels that psychiatry and what it can do, and what responsibilities one puts upon it, in a way has been over-sold. Psychiatry has its limitations. Its limitations depend upon a great many factors. So much stress has been placed upon certain factors that we have overlooked the affirmative approach, in which we develop the abilities of the individual to be able to live and get along with his neighbors. To be self-supporting and independent often solves his problems.

In paragraph 3, psychiatry has been exploited by those whom we might class as practicing charlantry, not only in our own profession (and we have had those who sign an M.D. to their name) but various cults, psychologists and others have exploited the subject of psychiatry without adequate mental and medical training, and have not the proper personality to so deal with personal relations.

On page 74, in regard to the establishment of a Section on Neuropsychiatry, a resolution already has been introduced by Dr. Gruber. We do feel that this would be proper, with the psychosomatic interpretations being such a large percentage as they are at the present time. If you will look over your program for this week's meeting you will find very little, if any, consideration given to those factors which produce in conservative estimates from 40 to 50 per cent of the complaints of people who ordinarily visit the doctor's office.

In the third paragraph on page 74 a little explanation might be given. You hear and read so much in the papers about the overcrowding of state hospitals, the inability to hospitalize patients. Anyone familiar with state hospitals or with private hospitals knows that there is a large percentage of patients who are not suicidal, who are not homicidal, who are not asocial or antisocial. There just wasn't any other place to put them because the general hospital would not take them.

To have a patient or a friend of yours, or even a member of your own family, adjudicated mentally ill, and placed in a state institution, is an irreversible psychic trauma to that individual, which follows him throughout his life.

Your Committee feels that the policy which is being adopted by large hospitals in the east, that of establishing a neuropsychiatric section in all large general hospitals, not calling it a neuropsychiatric section but just designating it as a section, is a wise move. Then so many of these patients with mild psychoneurotic symptoms, with mild psychotic symptoms, can say afterwards, "I was sent to St. Lawrence Hospital or Butterworth or Harper," without any psychic or emotional damage thereafter.

THE SPEAKER: Thank you, Dr. Luce. The supplemental report of the Committee on Mental Hygiene will be referred to the Reference Committee on Reports of Standing Committees.

Is there a supplemental report from:

X—k. COMMITTEE ON CHILD WELFARE
X—l. COMMITTEE ON IODIZED SALT
X—m. COMMITTEE ON HEART AND DEGENERATIVE DISEASES
X—n. COMMITTEE ON POSTGRADUATE MEDICAL EDUCATION
X—o. COMMITTEE ON PUBLIC RELATIONS

ARCH WALLS, M.D. (Wayne): This is not a long report. A great deal has been said this morning in regard to public relations by the Speaker of the House and Dr. Pino and Dr. Sladek, the Chairman of The Council. I have a supplemental report which refers to another project which your Committee has proposed to your Council for consideration during this session.

The report relates to the cinema, a sample of which will be shown here shortly and will last about eight minutes. It is put on by the J. M. Handy Corporation and through their courtesy. After the movie a public relations kit will be distributed to you, and we hope you will look it over very carefully.

The picture you are about to see is being shown in public theaters at the present time.

(The motion picture was shown.)

THE SPEAKER: Dr. Walls, do you have anything to say in addition to your supplemental report?

ARCH WALLS, M.D.: I would suggest—it has been proposed by your Public Relations Committee, and Dr. Sladek mentioned it in his report of the budget—that we get four cinema films. This is merely a sample that was put out last year by the J. M. Handy Company. I had the privilege of visiting that company last week, and find it is a very large organization, very capable of doing what they have done here. These films will reach nearly 400 theaters in the State of Michigan. They will extend through a period of six months, each one overlapping.

The cost will approximate $12,000 per cinema. When you think of the idea at first, it seems like a large sum of money; but when you consider that it will reach such a large number of people, it averages a little less than two cents per individual, which is much less, and we can send out envelopes to a few thousand people also.

This is submitted for your consideration during this meeting, and we hope some of the $25 assessment will be appropriated along this line.

THE SPEAKER: Thank you, Dr. Walls. This report will be referred to the Reference Committee on Standing Committees.

Is there any supplemental report from:

X—p. COMMITTEE ON ETHICS

If not, all of the reports as printed in the Handbook, pages 53 through 93, plus the supplemental reports given, will now be referred to the Reference Committee on Standing Committees.

XI. Reports of Special Committees

The next item on the agenda is reports of special committees. Is there a supplemental report from:

XI—a. COMMITTEE ON NURSES' TRAINING SCHOOLS

C. G. Clippert, M.D. (Medical Society of the North Central Counties, Grayling): I wish to make a few comments. I think you will agree with me that the doctors in their various sessions meet with many problems. Likewise we find the nurses run into difficulties when trying to solve some of their problems.

We considered inviting the nurses this year to meet with us. Still we ran into difficulties. Next year we intend to invite the officers of the Michigan Hospital Association together with the officers of the Board of Registration in Nursing and the officers of the Nursing Association, together with the doctors on the training of schools of nursing. I think when we can exchange ideas we will arrive at some common ground and will go forward and make progress.

A joint committee meeting of the Committee of Nurses Training Schools, the officers of the Board of Registration of Nurses and the officers of the Michigan State Nursing Association; also the Director of the Practical Nursing School of Detroit, held a meeting at Lansing, July 20, 1947.

The meeting was an informal one in which those present could express themselves as to how to improve the nursing situation in the State of Michigan. The consensus of those present was a need for more joint meetings to work out mutual plans and problems together; that with co-operation of the two groups, we can make progress for the benefit of both professions and the people whom we serve.

The resolution adopted by the House of Delegates of MSMS in September, 1946, (Item XII-6-j) was read and praised by Miss Ross who thanked the MSMS for its foresight and knowledge of the present nursing situation. Miss Ross gave the background of the creation of the new Nursing Center Association (formerly the Michigan Council on Community Nursing) which has a committee on practical nursing; she gave the concept of nursing—that a nurse should be prepared to do what the doctor requests her to do for the benefit of the patient. Miss Ross felt that the R.N. should have sufficient assistants to aid her to do skilled nursing.

The Michigan State Nursing Association realizing as well as the medical profession the inadequate nursing care available, appointed a committee in an effort to improve conditions. The committee worked out a program whereby the State Board of Control for Vocational Education supervises the education of practical nurses. Miss Fern Goulding outlined the course of training for practical nurses in the area of Michigan as follows:

The following *tentative plans* have been made for the conduct of the Nursing School of Detroit for the year September 2, 1947, to August 20, 1948, inclusive. (Don't get the impression that practical nursing schools are only for Detroit. As I will mention later, they are to be located through other sections of the state.) The plans will be submitted to both the Detroit Council on Community Nursing and the Department of Vocational Education of the Board of Education of Detroit for final approval.

(A) *Length of Course and Number of Students:*
The practical nursing course will be forty-eight weeks in length.
A class of forty-eight students will be admitted every eight weeks.

(B) *Cost of Course:*
A tuition fee of $50 will be charged, to be paid by the students in divided installments to the Board of Education. Students will be financially responsible for their own uniforms, books, and educational supplies, which will total approximately $45.

(C) *Course Content:*
The course will be divided into approximately sixteen weeks of class work, two weeks of observation, twenty-nine weeks of supervised practice in hospitals and other institutions of the city, and one week of final review. A breakdown of this plan is as follows:

1. Eight weeks of class instruction. (240 hours)
2. Eight weeks of supervised practice in the care of medical and surgical patients in co-operating hospitals. (320 hours)
3. Four weeks of class instruction. (120 hours)
4. Eight weeks of supervised hospital practice —four weeks each in the care of: (1) tuberculous patients and (2) obstetric patients. (320 hours)
5. Four weeks of class instruction. (120 hours)
6. Seven weeks of supervised practice in the care of: (1) the aged, and (2) infants and young children. (280 hours)
7. Two weeks of observation, one in the V.N.A. service and one in a nursery school. (60 hours)
8. Six weeks of supervised practice in care of patients in their homes. (240 hours)
9. One week of final review. (30 hours)

(D) *Total Hours of Instruction and Practice:*

Total hours of class instruction	520
Total hours of observation	60
Total hours of supervised practice	1,160
Total	1,740

Thus forty-eight weeks (1,740 hours), under supervision, would be given to forty-eight students, every eight weeks. These students would be between the years of eighteen and fifty, and could include men. Seven instructors already have been engaged. It is hoped that 500 in Detroit and sixty in every other center (tentatively in Traverse City, Marquette, Flint, Lansing, Grand Rapids or Muskegon, Battle Creek or Kalamazoo) will be trained; 1,860 per annum. The students will be paid during this training period a total of $580.

The term "practical nurses" according to Miss Ross is an inadequate title for these well-trained persons. In answer to a question, she stated that the recompense for trained practical nurses of this type would be 85c per hour (on the basis of an eight, ten or twelve hour day). She further stated that between 1,000 and 2,000 practical nurses are now licensed in Detroit.

The various nurses are divided into three classifications:

1. The R.N. (professional).
2. The trained practical nurse—on a par with the trained attendant (licensed by the state since 1921).
3. Auxiliaries.

Courses for practical nurses under the GI Bill of Rights (Referred by the MSMS Council to this Committee—Item 3-c of September 22, 1946, page 353 of the Council minutes): The nurses explained that this course for practical nurses is under the Michigan Department of Public Education, as above outlined.

The professional R.N. can be utilized to a better advantage for co-ordination of activities and a unity of total care with supplemental services rendered by practical nurses.

There is a serious shortage of nursing personnel in meeting needs for nursing service in hospitals. However, there are more nurses today than ever before; but the expanding needs and great demands for nursing service are the basic causes for our strained situation.

The following is borne out by a report of the Executive Secretary of the Michigan Board of Registration of Nurses. In 1936, 656 students out of schools were registered by examination as contrasted to 995 in the year of 1946.

The record of renewals is as follows:

1937—13,375 R.N.'s
1945—19,758 "
1946—20,956 "
1947—22,578 "

Statistics of employment of nurses were as follows:

1937—4,190 Institutional R.N.'s
1947—1,477 " "
1937—346 Office Nurses
1947—972 " "
1937—275 Industrial Nurses
1947—727 " "

Reciprocity

1937—542 Registered by reciprocity
1946—111 " " "

It was brought out that nurses are now doing many more procedures and in many more fields such as military service and that there is far more hospitalization than there was ten years ago.

It was also brought out that there was a definite need for the education of practical nurses, of R.N.'s of doctors of medicine, of hospital superintendents and of the public concerning this important matter of producing additional nurses and of receiving licensure for practical nurses.

The Committee felt encouraged and the outlook for relief for more efficient nursing in our hospitals seemed brighter.

(Vice Speaker Baker resumed the Chair.)

THE VICE SPEAKER: This supplemental report will be referred to the Reference Committee on Special Committees.

Is there any further report from:

XI—b. SCIENTIFIC RADIO COMMITTEE
XI—c. ADVISORY COMMITTEE TO WOMAN'S AUXILIARY
XI—d. SCIENTIFIC WORK COMMITTEE
XI—e. PROFESSIONAL LIAISON COMMITTEE
XI—f. BEAUMONT MEMORIAL COMMITTEE
XI—g. SPECIAL COMMITTEE ON RADIO
XI—h. POSTWAR EDUCATION COMMITTEE
XI—i. RHEUMATIC FEVER CONTROL COMMITTEE

H. H. RIECKER, M.D. (Washtenaw): This report supplements that of our Committee, printed in the Handbook, and is given to record the progress of the Rheumatic Fever Control Committee program subsequent to the printed report.

This report supplements that of our committee, printed in your Handbook, and is given to record the progress of the Rheumatic Fever Control Committee program subsequent to the printed report.

1. You will recall that the state is divided into districts, to which any physician in the state can send patients suspected of having rheumatic fever to a diagnostic group for consultation and advice as to treatment, prophylaxis and follow-up. These diagnostic groups consist of physicians especially trained in this disease and to maintain local autonomy are appointed by the county societies.

The *costs* of investigation and hospitalization (if necessary) of those children of borderline and indigent families are met by the Michigan Crippled Children's Commission, of which Dr. Carlton Dean is medical director. The costs involved in cases referred from families of a higher economic level are assigned a fee commensurate with the services rendered, and the money thus accumulated may be used as the local committee sees fit. The cost of maintaining the centers is graciously borne by the Michigan Society of Crippled Children and Disabled Adults, of which Mr. Percy Angove is executive secretary.

The committee has accepted an offer of the Alumnae of the Alpha Phi Sorority, who will form themselves into local groups for ancillary services, i.e., social service investigation, stenographic, nursing-aid, transportation, and lay education.

2. Our printed report referred to above concerned records from about one-half of the population of the state. Since that time the entire state has been activated in the program of case finding, diagnosis and follow-up. Under the stimulus of Dr. Norman Clarke, a member of the State Committee, fifteen centers are now organized in Wayne County to receive consultation requests from physicians in that area. A minimum budget of $4,500.00 has been provided to finance these centers and a central office provided gratuitously by the Wayne County Medical Society.

In Macomb County, a diagnostic group at Port Huron is now available. In Genesee County, two diagnostic groups are organized—one responsible for the upper and the other for the southern half of that county. A center at Flint eventually will be in operation.

Because of thorough and sincere attitude of the Grand Rapids center, under Dr. DeVel, and the support given by physicians of that area, the Central Committee found it necessary, in order to lighten the load of that center, to activate two new centers, one at Battle Creek and one at Muskegon. The same development has occurred in Bay County, and it was decided that Saginaw should accept a proportionate part of the load in this area.

To date, more than 650 children have been examined by the various diagnostic groups, of which about 25 per cent were found to have had or were having rheumatic fever. This figure would include less than one-half the population of Michigan.

A great need exists for convalescent hospitals for rheumatic children. Four or five of these should be erected in strategic areas. Definite steps are now being taken by your chairmen toward this objective.

With the activation of the entire state in a unified effort, and with rapidly increasing diagnostic acumen, it is believed that our report next year, the first covering of the entire state, will be truly gratifying to the Council and House of Delegates, but more importantly to the people of Michigan and their family physicians.

May I call your attention to a State Study Club to be organized this week under the leadership of Dr. Moses Cooperstock. May I ask the delegates to report to their county societies that any member seriously interested in the disease, and in following progress in study and research of rheumatic fever, may apply for membership.

Scientific and clinical discussions will be held at stated intervals. Younger men of promise in any community will be given an opportunity to visit various clinics in the country, and bring to us directly any helpful information or criticism applicable to our State Program. This study club, authorized by the Council, provides a unique educational opportunity and forms an important allied activity of the profession.

I might list, at the risk of reiteration (which Shakespeare said is no sin), the principles guiding the committee in its work, in the hope of giving you a better sense of orientation, and a better understanding of the spirit of our participating physicians in a pioneering effort, and perhaps a modest example of the possibilities in beneficient altruism of the profession of medicine.

The primary concern of the State Committee for the Control of Rheumatic Fever *is the child who has the disease.* Our objective centers upon the child. No other con-

sideration is involved—*the potential or actual disease in any child in Michigan, regardless of economic status,* constitutes our sole objective. I will say this to the officers and members of the House of Delegates: that this committee and its regional committees and its associated organizations are working with all the altruistic fervor that the spirit of humanity can summon to bring this objective to fruition. We are obligated to prove to the severest critics of organized medicine that *every child in Michigan* is being given the best treatment available, the most complete prophylactic follow-up, and adequate convalescent and occupational guidance.

There is no conscientious physician in the world who will admit he can make the diagnosis of rheumatic fever in one visit, or rule out its presence in every single case. Because of the physical and psychic implication involved in a decision of this kind, its responsibility should be shared, regardless of the skill of the individual physician. Extreme vigilance is necessary to protect a child from psychic trauma as well as to care for one who has rheumatic heart disease.

Our working principle (in contra-distinction to our objective) consists of following a *sound method* in obtaining our objective. The objective can be reached by strict adherence to the principles of the practice of medicine from legal, forensic, ethical and organizational standpoints. In other words, we know and will adhere constantly to these standards.

Our working rule consists of adhering to *time-proven methods to consummate our objective. These methods* are in complete *agreement with the principles of the private practice of medicine in this state.*

I wish to emphasize that we have one objective, and that our methodology in obtaining this objective has been agreed upon universally by leaders of the organized medicine. The Central Committee does not agree with those who advocate, and support in many areas, the proposition that rheumatic fever can and should be controlled by the application of Public Health methods. We believe the Michigan approach to this 150-year-old problem will be successful. If by our methods, so earnestly defended by organized medicine, we do not gain our objective, then I would say the fault will be found in the opinioned scholasticism of the isolated individual physician, and not through a faulty interpretation by our committee, of the principles guiding private practice.

The challenge presented, in an effort to control rheumatic fever in the state, *transcends* any one, or any small group of physicians. A defeat of the program by non-co-operation with regional diagnostic groups in any area, is an admission of failure of the principles of the private practice of medicine in the state, and by implication, in the nation as well.

This society has always shown leadership and initiative and has ranked far above other state organizations, as well as the national organization, in providing solutions to constantly new, and often difficult, problems confronting the medical profession. In some few of our activities, lack of intelligent leadership caused the gradual death of an ideal.

In the problem of rheumatic fever control, the officers and members of the Michigan State Medical Society are demonstrating again that a state medical society can function effectually attempting to make history by substantiating the following facts:

1. That rheumatic fever *cannot be controlled by Public Health methods,* as in typhoid fever, smallpox, rabies, malaria, brucellosis, and certain other infections.

2. That our physicians' organizations, its facilities and leadership are available to accept the challenge of solving any problem within its own domain.

3. That many of these problems are best managed at the state and community level, rather than by the Federal Government.

4. That co-operation with ancillary and friendly organizations within the state usually is not only necessary to success in solution of a —medical, economic, or social —public health problem, but highly desirable from the standpoint of public relations.

In concluding, I would ask you to take back to your constituents these statements: The dangers of failure of one of the most widely observed projects ever undertaken by a state medical society is not the lack of money, of organization, of vision and leadership, of public appreciation. We of the committee fear only apathy on the part of our doctors, apathy with respect to co-operation with regional diagnostic centers, and apathy toward participation in continuing professional and lay education. In this we are confident that you will not fail.

THE VICE SPEAKER: Thank you, Doctor. The supplemental report of the Rheumatic Fever Control Committee will be referred to the Reference Committee on Special Committees.

Is there a further report from:

XI—j. CONTACT COMMITTEE WITH ASSOCIATION OF WELFARE BOARDS AND BOARDS OF SUPERVISORS
XI—k. COMMITTEE ON STATE VETERANS AFFAIRS
XI—l. JOINT COMMITTEE ON INFECTIOUS DIARRHEA
XI—m. COMMITTEE ON UNIFORM FEE SCHEDULE FOR GOVERNMENTAL AGENCIES
XI—n. COMMITTEE ON RURAL HEALTH
XI—o. COMMITTEE ON COURSES IN MEDICAL ECONOMICS
XI—p. COMMITTEE ON MICHIGAN HIGH SCHOOL ATHLETIC ACCIDENT BENEFIT FUND
XI—q. COMMITTEE ON NATIONAL EMERGENCY MEDICAL SERVICE
XI—r. COMMITTEE TO MEET WITH CONGRESSMEN
XI—s. INDUSTRIAL STUDY COMMITTEE
XI—t. COMMITTEE ON REVISION OF CONSTITUTION AND BY-LAWS

(The Speaker resumed the Chair.)

THE SPEAKER: If there are no more reports from any of the special committees, all the supplemental reports and regular reports will be referred to the Reference Committee on Special Committees.

VIII—n. ON REPORT OF SPECIAL COMMITTEE TO STUDY THE MEDICAL PRACTICE ACT

W. B. HARM, M.D. (Wayne): Mr. Speaker, I have a resolution.

"WHEREAS, the report of the Special Committee appointed to study the Medical Practice Act has not been presented to the House of Delegates, and

"WHEREAS, this Committee needs the support of the entire membership in order to continue its work, and

"WHEREAS, the House of Delegates represents by election the component county societies, who are in close contact with the individual members, and

"WHEREAS, the By-Laws state that the House of Delegates 'shall concern itself and advise as to the interests of the profession and of the public in those matters of legislatition pertaining to medical education, medical registration, medical laws and public health,' and

"WHEREAS, this report recommends a revision of the present Medical Practice Act which is of vital concern to all doctors in Michigan, and

"WHEREAS, it is imperative that action be taken on this matter as soon as possible; be it therefore

"RESOLVED: That the report of the Committee to Study the Medical Practice Act be presented to this House of Delegates in Executive Session."

THE SPEAKER: Thank you, Dr. Harm. This resolution will be referred to the Reference Committee on Reports of The Council.

Is there any more new business?

(The meeting recessed at 6 p.m.)

Second Meeting

Monday Morning, September 22, 1947

The meeting convened at 10:10 a.m., J. S. DeTar, M.D., Speaker of the House of Delegates, presiding.

THE SPEAKER: The House will please come to order.

May we have the report of the Credentials Committee.

J. J. O'MEARA, M.D.: Mr. Speaker, I hold in my hand the credentials of eighty-seven applicants, more than necessary to form a quorum, and 50 per cent of which are not from any one county.

THE SPEAKER: The report will be considered as a roll call.

The next order of business is unfinished business. Is there any unfinished business to come before the House at this time? If not, is there any new business to come before the House at this time?

Are there any additional resolutions to be introduced?

VIII—o. CANCER DETECTION CENTERS

L. W. HULL, M.D. (Wayne): I have a resolution in regard to cancer detection centers.

"WHEREAS, great publicity programs and widespread organization of lay agencies on a national scale have stimulated an unprecedented public interest in and demand for the detection and control of cancer, and

"WHEREAS, such public interest and demand are being implemented by means of cancer detection clinics, by legislative aids for the investigation and study of cancer, and by public and private grants of funds for various activities in relation thereto, and

"WHEREAS, many of such well-intentioned projects may become misdirected, dissipated or otherwise diverted from their primary purposes unless they are given competent professional medical leadership and direction, and

WHEREAS, the public has at all times had reliance on doctors of medicine for the detection and control of cancer; now, therefore, be it

"RESOLVED: That the Michigan State Medical Society does reaffirm its purpose to stimulate, encourage and assist all proper measures for the detection, study, treatment and control of cancer; and be it further

"RESOLVED: That each county or district medical society of Michigan, either by itself or in conjunction with the surrounding county groups, is urged to create facilities for the appropriate handling of the cancer problem, and that it be responsible for cancer activities in its own area; and be it further

"RESOLVED: That these facilities be used for the detection of cancer among those who are not able to employ the services of a doctor of medicine; and be it further

"RESOLVED: That any expansion or alteration of such a program be undertaken only by the approval of the county medical society."

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions.

Is there any further new business? If not, the next order of business is the reports of reference committees.

The Chair will call upon the Chairman of the Reference Committee on Officers' Reports, Dr. C. W. Oakes, to present his report.

XII. Reports of Reference Committees

XII—a. ON OFFICERS' REPORTS—SPEAKER'S ADDRESS

C. W. OAKES, M.D. (Huron): Mr. Speaker, the report of the Speaker is approved, and we commend the report in its entirety.

XII—a. PRESIDENT'S ADDRESS

We compliment President Hyland on his address. Although short, it was concise and to the point.

XII—a. PRESIDENT-ELECT'S ADDRESS

Dr. P. L. Ledwidge's address as President-elect was of the same sterling quality and sincerity as his speeches have been in the past, while he was Speaker of the House. We approve of his report without reservation.

XII—a. REPORT OF DELEGATES TO AMA HOUSE OF DELEGATES

The report of the Delegates to the American Medical Association consists of two sections, A and B, A being the Chicago interim meeting of December, 1946, and B the annual meeting for 1947 at Atlantic City. We compliment the Delegates on their diligent work in two hard sessions, and their detailed and accurate report. Mr. Speaker, I move the adoption of this report as a whole.

ANDREW VAN SOLKEMA, M.D. (Kent): I support the motion.

(The motion was put to a vote and was carried unanimously.)

XII—a. ON EXPENDITURES IN U.S. EXECUTIVE DEPARTMENTS

C. W. OAKES, M.D.: We have another resolution from Genesee County, introduced by Dr. Morrish, relative to the "investigation of the participation of Federal officials in the formation and operation of health workshops." We approve this resolution and move its adoption.

THE SPEAKER: Is it clear what motion this is? Would you like to read the resolution?

C. W. OAKES, M.D.: It is a long one. I think Dr. Morrish knows more about this than I, and he can explain the whole thing.

THE SPEAKER: This resolution was read before the House yesterday. Would the House care to hear the Resolved portion of this resolution, without the preamble?

E. D. SPALDING, M.D.: I move that this motion be read by title at this time.

HARRY LIEFFERS, M.D. (Kent): I second the motion.

(The motion was put to a vote and was carried unanimously.)

C. W. OAKES, M.D.:

"WHEREAS, House Report 786, 80th Congress, entitled 'Investigation of the Participation of Federal Officials in the Formation and Operation of Health Workships,' shows evidence that there have been violations of Section 201 of Title 18 of the United States Code by employes of the departments and agencies specifically mentioned in the report, and

"WHEREAS, it was suggested and recommended by the Subcommittee on Publicity and Propaganda of the Committee on Expenditures in the Executive Departments that 'action be taken by the Attorney General of the United States to prosecute these violations, and to prevent further disregard by Federal employes and agencies of the law cited'; therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society does approve of the purpose of the investigations made by the Subcommittee on Publicity and Propaganda of the Committee on Expenditures in the Executive Departments, and does commend its fearless presentation of evidence uncovered during its investigation, and does hereby urge the Attorney General of the United States to give careful consideration to the recommendation of this Committee, and that the Subcommittee be advised of the action of the House of Delegates by sending a copy of this resolution to its Chairman, the Honorable Forest A. Harness of Indiana; and

"RESOLVED: That additional copies of this resolution be sent to the Speaker of the House of Representatives, the Honorable Joseph W. Martin, Jr., Washington, D. C., and also to the Chairman of the Committee on Expenditures in the Executive Departments, the Honorable Clare E. Hoffman of Michigan, and to the Attorney General of the United States, the Honorable Tom C. Clark."

The basis for this matter is that the Federal government and certain agencies in it have been using Federal money to exploit certain reforms, such as the Murray-Wagner-Dingell Bill, and they are trying to get Federal state medicine. Right now there is a commission in the Philippines trying to put this thing across in Japan and the Philippines, without any authorization. They are using these Federal funds to promote socialized medicine. This resolution asks for an investigation. We are to inform our senators and representatives in Washington to look into it. Is that clear?

THE SPEAKER: Are you ready for the question? Do you care for a further explanation?

S. L. LOUPEE, M.D. (Cass): I would like to know something more about this proposal. What is the concluding paragraph of the resolution? That is what we need.

THE SPEAKER: Will you read that, Dr. Oakes?

(Dr. Oakes read the final "Resolved.")

THE SPEAKER: Is there further discussion?

S. L. LOUPEE, M.D.: The purpose of this proposal undouhtedly is correct, but we should do something to disclose the activities

of the agencies in the Federal government that are spending money without control. If any member of this organization is weak enough to believe that by appealing to Tom Clark we are going to get any action, he is just being silly. Nothing whatever would be done.

If you want to approach this from a different angle, if you would like to call the attention of our senators and every member of the Michigan delegation to it, and get them to work on it as representatives of the Michigan State Medical Society, we might get something done. But you will never get anything done if you appeal directly to the Attorney General's department.

THE SPEAKER: Any further discussion?

R. S. MORRISH, M.D.: I hope everyone present will take it upon themselves to get a copy of House Report 786 of the 80th Congress, 1st Session. It is the third intermediate report of the Committee on Expenditures in Executive Departments, of which Congressman Forest K. Harness of Indiana is the Chairman.

This Committee is making up a survey of alleged illegal expenditures of money, which runs up to as much as 75 million dollars, with the idea of offering propaganda on behalf of such bills as the Murray-Wagner-Dingell Bill.

The organizations under investigation by this Committee, and also certain individuals, by the Federal Bureau of Investigation —and these individuals' names are familiar to you particularly if you have been reading any of the reports issued by Marjorie Sherman—the organizations under scrutiny are the Public Health Service, for one. You probably remember the letter sent out last year by Dr. Thomas Perrin, urging everybody in the United States Public Health Service to get behind President Truman's effort to bring about socialized medicine. Another organization is the Children's Bureau, also the Office of Education, the United States Employment Service, the Department of Agriculture, and the Bureau of Research and Statistics of the Social Security Board.

This Committee reports: "Your Committee finds that the use of federal funds for the purpose of influencing legislation before Congress is unlawful under Section 201, Title 18 of the United States Code. We have therefore brought these matters to the attention of the Department of Justice, with the request that the Attorney General at once initiate proceedings to stop this unauthorized and illegal expenditure of public moneys."

Mr. Harness has sent a letter to the Honorable Tom Clark, asking that he prosecute these agencies with the information he has secured.

Our purpose in offering this resolution was simply to give support to Congressman Harness. As Dr. Loupee said, we can't expect anything from Tom Clark, but we can expect something from Tom Clark if we needle him enough, and if enough organizations such as ours needle him enough. Certainly Forest K. Harness and our own Clare Hoffman, who is the Chairman of the Committee on Expenditures in Executive Departments, will get our support, also the Speaker of the House. Our purpose is to give these people our moral support. They will handle Tom Clark if anybody can. I realize we can't handle him, but at least we can offer our help.

S. L. LOUPEE, M.D.: As I stated at the start, I am heartily in favor of this resolution. I believe this organization should support the members of Congress who are making an effort to curtail federal expenditures. I know Clare Hoffman very well, and I know he is definitely in earnest when he starts out to accomplish this. He is going to do it if it is humanly possible. It is just barely possible this resolution will do what we want it to do. I hope it will be made as strong as we can possibly make it, and I hope this organization will get behind this movement and give it our support.

I am willing to vote for this resolution as it stands, if it is the best you can prepare.

(The motion was put to a vote and was carried unanimously.)

THE SPEAKER: Is there any further report from the Committee?

C. W. OAKES, M.D.: Mr. Speaker, I move we adopt the report of the Committee as a whole.

R. A. SPRINGER, M.D. (St. Joseph): I second the motion.

(The motion was put to a vote and was carried unanimously.)

THE SPEAKER: The next order of business is the report of the Reference Committee on Reports of The Council.

XII—b. ON REPORTS OF THE COUNCIL

W. B. MITCHELL, M.D. (Kent): Mr. Speaker, first we will take up the recommendations of The Council, as reported on page 50 in the Handbook.

The first recommendation.—The Committee recommends that the House of Delegates accept this recommendation, and I move its adoption.

THE SPEAKER: Dr. Mitchell, I don't believe you will have to move the adoption of each separate recommendation, until you are ready to move the adoption of the report of the Council as a whole.

W. B. MITCHELL, M.D.: Thank you. We will take them altogether, then, 1, 2, 3, 4 and 5, and the supplemental recommendations as given in the supplemental report.

No. 2.—The Committee recommends that the House accept this recommendation.

No. 3.—The Committee recommends that the House accept this recommendation, with emphasis on the clause beginning "The Council again recommends that the House of Delegates urge all component county and district medical societies to make every effort, within the next few months, to negotiate necessary revisions in schedules of benefits covering governmental wards so that individual members of county societies are not penalized by being forced to perform services at a financial loss and below the fees either charged private patients in their particular areas or those indicated in the Uniform Fee Schedule for Governmental Agencies."

No. 4.—The Committee recommends that the House of Delegates accept this recommendation.

No. 5.—Not considered in view of the supplemental recommendation.

Supplemental Recommendation No. 1.—This was considered, and the following recommendation is made by the Committee to the House of Delegates: "That the House of Delegates authorize the continuation of a progressive public relations and public education program of the Michigan State Medical Society, and that it finance this important and necessary project by a per capita membership assessment of $25 for the year 1948."

Supplemental Recommendation No. 2.—"That the House of Delegates consider the granting of life membership to doctors of medicine who have obtained the age of seventy years and who have been members of the Michigan State Medical Society for a period of twenty-five consecutive years or more" was considered, and it is recommended that this be referred to the Committee on Revision of the Constitution and By-Laws.

The adoption of *Supplemental Recommendation No. 3* is recommended as follws: "That the membership of this House of Delegates take back to their county societies the information regarding the American Medical Association's gold medal award for an outstanding general practitioner; that efforts be made to locate the Michigan candidates for this award, and that nominations, together with complete substantiating data, be submitted to the Executive Committee of The Council before its November meeting so that a Michigan candidate or candidates may be selected for submission to the headquarters of the American Medical Association."

The Committee reviewed the report of The Council and the supplemental report of The Council in detail, and takes this occasion to express its compliments and appreciation for the high caliber of work and the extraordinary devotion to duty by members of The Council.

XII—b. ON TENURE OF STATE HEALTH COMMISSIONER

Consideration of resolutions:

A resolution concerning Dr. DeKleine, presented by Dr. Bloemendaal of Ottawa County: The Committee recommends that this resolution be not adopted.

XII—b. ON REPORT OF THE SPECIAL COMMITTEE ON STUDY OF MEDICAL PRACTICE ACT

A resolution concerning the report of the Special Committee on Study of the Medical Practice Act: It is recommended by this Committee that the report made to The Council by the Special Committee to Study the Medical Practice Act be not presented to the House of Delegates at this time, in view of the fact that the work is incomplete.

XII—b. ON RATIO OF MEDICAL OFFICERS IN THE ARMED FORCES

A resolution concerning the reduction of the ratio of physicians to the personnel in the armed forces: It is recommended to the House of Delegates that this resolution be not adopted.

It is recommended that the general outline of the complaints, as enumerated by the Chairman of The Council in his report to the House of Delegates regarding doctors of medicine, be taken back to their component societies for discussion and consideration.

These are the recommendations of the Reference Committee on the Reports of The Council, and I move their adoption as read.

THE SPEAKER: The motion is that the report of The Council and supplemental report be adopted as read, with the additional recommendation, Dr. Mitchell, that Section 2, recommendation 2, on life memberships, be referred to the Reference Committee on Amendments to the Constitution and By-Laws.

L. G. CHRISTIAN, M.D. (Ingham): I second the motion.

THE SPEAKER: Is there any discussion?

E. D. SPALDING, M.D.: Mr. Speaker, I have several remarks I would like to make on this subject.

My remarks will be confined entirely to that portion of The Council's report that has to do with the proposed program of the Public Relations Committee. There are many of us in this room who are willing and glad to contribute $25, or more if necessary, to any proper cause, but we are not willing that this be spent as it is proposed, and at this time.

The Public Relations Committee has outlined in this brochure, which was handed to us with the supplemental report to the Council yesterday, much that is worthy of consideration, and it also contains much that is false and highly unwise.

This Committee proposes that a $135,000 budget be spent this year, of which $25 from each member will raise somewhere from $107,000 to $116,000, requiring the dipping into the reserves of $60,000 to the tune of nearly 50 per cent.

Not only the spending of the $25 to be assessed this year, but practically half of your reserve in addition, at a time when the sun is shining and the wind is not blowing. What are you going to leave in the reserve for the time when the weather is more inclement?

There are a number of objections, some of which I will voice and others which will be discussed from the floor by others. The question of the radio as a valuable means of approaching the public: Some of the material that has been put out over the radio is of small interest to the general listening public, and can be improved upon.

The question of the movies: If the movie script that was shown yesterday is an example of the type of thing that is going to be foisted on the public, some revision of it will have to be made. May I call your attention to one very brief episode in the movie, in which the young practitioner comes in, feels the man's pulse without taking out his watch, looks at the patient's tongue, and promptly writes out a prescription for sulfathiazole, without even examining the patient! If that is good public relations I'll eat it!

Some of us object very definitely to this matter of newspaper advertising. I think we feel that in this regard we are interested in informing the public, but not advertising the profession. The Speaker of this House yesterday, in addressing you on this same subject, raised the point that last year a delegation objected to newspaper advertising in one county of this state, stating the fact that we objected to the wasting of money by such advertisements. It is not the waste of the money that was objected to, but the appearing of such an advertisement advertising the profession, which we felt was not the best way to approach the public.

I call your attention to the fact that in the meeting in Owosso, when the Public Relations Committee convened to lay out a plan for the expenditure of $60,000, at the beginning of that meeting there were seven men of a twenty-six-man Committee present, and at the close of the meeting there still was no quorum.

This is not a business-like way to dispense with $60,000 of the state's money. Understand again, I am in no way objecting to the raising of $25, or more if necessary, if a good and proper use can be made of it; but the brochure as handed out yesterday is not my conception of a proper application of funds.

Therefore, Mr. Speaker, I move an amendment to the motion to adopt The Council's report, that that portion of The Council's report which applies to the endorsement of the program of the Public Relations Committee be not adopted.

W. W. BABCOCK, M.D. (Wayne): I support the motion.

THE SPEAKER: You have heard the amendment as proposed, that that portion of the report referring to the $25 assessment be not adopted. Is there any further discussion on the amendment?

E. D. SPALDING, M.D.: Mr. Speaker, you misquote me. I am referring to the program, not to the $25.

R. S. BREAKEY, M.D. (Ingham): I understood the amendment to refer to the means of application. I want it clear whether we are voting on the assessment or the application.

E. D. SPALDING, M.D.: The program.

VOICE: Will you read the amendment again?

(The reporter read the amendment).

B. T. MONTGOMERY, M.D. (Chippewa-Mackinac): Does Dr. Spalding mean to eliminate our program on public relations or has he some substitute?

THE SPEAKER: Dr. Spalding, would you care to answer that question?

E. D. SPALDING, M.D.: I think my remarks will stand as they were issued. It seems to me it was rather obvious that I do not approve of the program as outlined in this brochure.

L. G. CHRISTIAN, M.D.: Mr. Speaker, may we hear from The Council on this? Do they have the information? I am sure many of us do not know all about it.

THE SPEAKER: Dr. Christian has asked that Dr. Sladek speak for The Council on this matter.

E. F. SLADEK, M.D.: Gentlemen of the House of Delegates, the public relations program as outlined is probably not the final program which will be instituted. In order to budget a proposed program, or budget the expenditure of a fund which we raise, certain projects must be proposed. The projects are a development of our experience during the past two years in trying out various media of public relations and media attempting to influence the attitude of the public.

Every item of the public relations program, before a penny is spent on it, is brought before The Council and is thoroughly discussed. I think you members of the House of Delegates would be markedly surprised at the number of proposed projects which The Council turns down.

The pamphlet as prepared and placed in your envelopes is an outline of possible things. For instance, the movie you saw yesterday isn't the movie we propose or that the Public Relations Committee proposes to put on the screen.

E. D. SPALDING, M.D.: Then why was it shown?

E. F. SLADEK, M.D.: It was shown as an example of the type of work this company does which has been contacting the manufacturer, and who put on the program and the movie, just as an example of the type of work they do. It was a March of Time film from last year or the early part of 1947. It is proposed that in the making of this movie we have checks on original script as written. There will be suggestions for the four types of movies. There will be a check on the script, a medical check after the first revision, a thorough medical check by a committee of doctors; then before it is actually acted upon there will be another check, I understand, with an M.D. around when they are actually taking the picture. Before it is released this medical committee must okay it. If they do not okay it there will be no cost to the Society.

In other words, the company has guaranteed that the movie will be fully satisfactory to the Public Relations Committee and to the Council of the Michigan State Medical Society. There will be plenty of checks on that movie.

As far as the rest of the program is concerned, as I said, all of the projects are checked through The Council

Are there any other questions?

DOUGLAS DONALD, M.D. (Wayne): I would like to ask Dr. Sladek a question: I didn't see anything proposed as an expenditure for the education of the doctor.

You spoke yesterday evening at some length on good private relations. I am one of those unfortunate old-fashioned individuals who still thinks that is the best public relations there is. I would like to see something in this program advancing better private relations, which you expressed so beautifully in your talk last night.

E. F. SLADEK, M.D.: Thank you. Concerning the education of the doctor, The Council holds district councilor meetings in various councilor districts, supposedly every year. It is often hard to get out an attendance at those meetings.

In January we have our Secretaries' Conference, which is a stimulating meeting, and at which a tremendous amount of information is brought to the secretaries and to the public relations committees of each individual county society. The Public Relations Fund pays the expenses of the secretaries and the members of the public relations committees who attend that meeting. That is a stimulating meeting. If the secretaries carry that information back to their county societies—which some, not all, of them do, unfortunately—the doctors are distinctly educated along social-medical-economic lines.

We also propose, I believe, the issuance of pamphlets from time to time. Most doctors don't read pamphlets; that is one of the sad commentaries on them.

E. D. SPALDING, M.D.: Are you referring to "Joe Genius?"

E. F. SLADEK, M.D.: There hasn't been a "Joe Genius" pamphlet published in about two years.

E. D. SPALDING, M.D.: I heartily applaud that! (Laughter)

E. F. SLADEK, M.D.: As I tried to say, we can't outline a specific program because things come up that may change our attitude and our type of attack of lay education. We don't know but that in January there is going to be a tremendous amount of activity in Washington on the Murray-Wagner-Dingell Bill. In the hearings on the Taft Bill, two of which I have attended, some of the opposition senators were very, very definite that some sort of program be put into action, and that a vote in the Congress would be taken on some form of health legislation early in 1948.

If any of you have followed the reports of the hearings in the American Medical Association *Journal*, you know that following the doctors' testimony and testimony by the proponents of the Taft Bill, Senators Murray and Pepper brought in a tremendous amount of testimony opposing the Taft Bill and very, very definitely substantiating the principles of the Murray-Wagner-Dingell Bill.

I think things are going to be serious in Washington in 1948.

E. D. SPALDING, M.D.: Then why expend your budget before it gets serious?

E. F. SLADEK, M.D.: The budget won't be expended before it gets serious.

E. D. SPALDING, M.D.: You are already dipping $30,000 out of the reserve, as well as spending the current assessment.

W. B. HARM, M.D.: I notice in the budget this year that there is no reserve set aside. When the original assessment was put on, I think it was the understanding that it would be built up to a reserve of $100,000.

E. D. SPALDING, M.D.: They are depleting their reserve of $30,000, or 50 per cent.

W. B. HARM, M.D.: At the present time they have $60,000 in the reserve. We understood this reserve was to be used for public relations. Wayne County says The Council has a right to use this reserve for anything they wish. It was not set aside directly for public relations.

Are we going to continue to build up the reserve for an emergency, such as Dr. Sladek was talking about just now, or is $60,000 considered by The Council enough reserve?

E. F. SLADEK, M.D.: I would like to call on the Chairman of the Public Relations Committee to answer that question.

THE SPEAKER: Will the Vice Speaker please take the Chair?

(Vice Speaker Baker resumed the Chair)

H. H. RIECKER, M.D.: Are we voting on this resolution for the assessment? Are we discussing that?

THE VICE SPEAKER: We are discussing the amendment.

H. H. RIECKER, M.D.: Is the assessment now up for vote?

THE SPEAKER: Mr. Vice Speaker, this becomes more and more involved. I stated in my Speaker's Address that I did not care to take part in any argument. I wanted to be absolutely impartial. However, I have been asked, so I will state a point of view.

The Public Relations Committee did not spend as much money as was appropriated this past year, by something like $12,000 to $14,000. This budget which has been brought up for next year includes every item that the Public Relations Committee felt we would like to see put through next year. However, before any item is spent the Council must authorize that expenditure. That has been the experience this year.

Regarding the $60,000 in the reserve fund, the Council specifically stipulated, when the additional $30,000 was taken out of the 1947 budget (the fund for 1947), that that money would be put into the reserve fund along with the $30,000 from last year, and be specifically earmarked for public relations purposes, and cannot be used for any other purpose.

Regarding the proposed program of the movies, we are not sticking our necks out too far on this matter. True, there is $48,000 in the budget; however, the J. M. Handy Company would have a contract with us to produce the first picture. It would cost the State Society $3,000 on the signing of that contract, according to my understanding. The work would be done. When the movie is one-fourth finished—and, incidentally, we would have and we must have medical consultation all the way along, from specialists in various lines, from general practitioners; we must have adequate coverage of such a project as this which represents us on the screen before so many people, and we would have that. I am sure the Chairman of the Public Relations Committee will be certain that we are protected in that regard.

We would spend $3,000. The picture would be finished; another $3,000. We would check it. We would pay 25 per cent each time until we have finished the production of the movie. That is $12,000. Then it would be put into theatres and put on the market.

The question arises: Are we sure the movie would go into the theatres? The J. M. Handy Company is not willing, as I understand our relationship, to guarantee absolutely that it will go into 400 theatres, but the representative of the company, who has been with us on the Council talking over the matter, has said that it has been the policy of the company, although it is not put in the contract. True, without that in the contract we might be taking a chance on $12,000 of our funds; however, it has been their experience that in making similar pictures for other organizations, those movies have been good enough so that the theatres have wanted them, and the pictures have been shown on the screen.

It would cost an average of something like two cents per person to whom it is shown, to have it shown throughout the theatres in Michigan.

While I have the floor as Past Chairman of the Public Relations Committee, are there any other questions anyone would like to ask me?

E. D. SPALDING, M.D.: How was action proposed on the $60,000 expenditure without a quorum being present?

THE SPEAKER: Dr. Spalding, it is very difficult to get committee members to attend all meetings.

E. D. SPALDING, M.D.: Does it make it legal?

THE SPEAKER: That question was brought up at the meeting of the Public Relations Committee in Owosso. The members of the Public Relations Committee were written one notice of the meeting and were sent second letter. Every effort was made to get them there. However, we know of nothing in the Constitution which requires that a quorum be present at committee meeting to make the actions of that committee meeting legal and binding. If you know of any—

E. D. SPALDING, M.D.: Robert's Rules of Order. Would you care to read it in that?

THE SPEAKER: Would you care to read it, Dr. Spalding?

E. D. SPALDING, M.D.: No, but I can if you want me to.

THE SPEAKER: Does the House care to go into this matter further regarding whether the actions of the Public Relations Committee in Owosso could be considered as binding?

(Cries of "No!")

THE SPEAKER: Gentlemen, at that Committee meeting all the members of the Committee who could be corraled together were there. The recommendations were made by that Committee; they were sent to The Council. No recommendation of any committee is binding, and no expenditure can be made, until The Council has authorized it.

The Council took the recommendations of that Committee and altered those recommendations and submitted them, and those recommendations you have in your brochure are as corrected by the Council. However, that is only a tentative budget, and if I have answered as many questions as you care to have me answer I will turn the floor back to Dr. Sladek.

(The Speaker resumed the Chair)

H. F. DIBBLE, M.D. (Wayne): There isn't a man in this House of Delegates who doesn't realize we need this $25 assessment. This arguing and bickering about what you are going to do with it—the men who do serve on the Council, we feel, are capable of spending our money the right way. All this bickering reminds me of the fellow who needed a car for a whole year. He sent his wife down to get it, and she came back without it. She said, "Dear, it's the wrong color!" (Laughter)

W. B. HARM, M.D.: I still would like to find out about the $60,000. We were told it cost California $200,000 in their budget for compulsory health insurance. Isn't that the purpose of this fund—to build it up? I don't mind spending the assessment, but I want to see it put some place where it is going to be useful. I don't think $60,000, if we have a fight on our hands here, is going to amount to very much.

From hearsay you already have the $60,000, and you are afraid if you don't spend some of it the members won't go for the $25 assessment. I am still in favor of putting some of that into the reserve.

THE SPEAKER: Dr. Harm, may I answer that question? There was one point at the Owosso meeting that I perhaps didn't make clear.

The Public Relations Committee did vote to use the $30,000 from the 1947 assessment in the 1948 program; however, The Council, in checking over the minutes, did not approve of that recommendation, and put the $30,000 for 1947 into the reserve fund, making it $60,000.

Are there any other questions?

W. W. BABCOCK, M.D.: It seems to me that if we accept the report of The Council we commit ourselves to the program as outlined. I don't think we should do that. We are getting in a Public Relations Committee, and I think they should have a free hand and that their hands should not be tied. I am also not against the $25.

It also seems to me that perhaps the present ideals, as outlined by the Public Relations Committee, are based on a false premise. They are based on the premise of advertising.

I oppose the principle of any professional group advertising themselves to the public. In my opinion group professional advertising is as bad as individual advertising. I think the discussion of advertising cheapens doctors as a group and lowers them to the class of the cultists. We have maintained our status above those cultist groups without advertising.

I don't think the program as outlined will change national or state legislation one iota. I personally don't see any tangible return from the moneys already spent by our public relations program.

I know the rank and file of doctors, who elected me as a delegate (because I have contacted and interviewed some of them), are dissatisfied with the public relations program and the way the money has been expended. They don't see the results.

It seems to me we perhaps could take a hint from the American Medical Association, which has curtailed its public relations program drastically or entirely eliminated it. I do agree with all the previous speakers that we do need a reserve for contingencies, and I am in favor of the $25 assessment to be used at the discretion of The Council. I feel The Council should hear the expressions of the delegates, so they can best regulate the spending of this money and the way it is to be distributed.

THE SPEAKER: Are there any other questions any other delegate cares to ask Dr. Sladek while he is on the platform?

L. G. CHRISTIAN, M.D.: As a member of this Committee, I feel that the Committee was not given this information. I feel these men should have come in and voiced their objections when we were meeting. We are getting no place, and I know there is a motion before the House, but I would like to request that this be sent back to the Committee. Let these men come in and advise us so we can make some decision.

THE SPEAKER: Dr. Christian, in order to fulfill that request you would have to move that this be referred back to the Reference Committee for further consideration.

L. G. CHRISTIAN, M.D.: Will you accept that motion?

THE SPEAKER: Yes.

L. G. CHRISTIAN, M.D.: I move that this portion of the report be sent back to the Committee for further consideration.

H. F. DIBBLE, M.D.: I second the motion.

THE SPEAKER: The motion is that the section of the report dealing with the matter of the spending of the $25 assessment during the year, as outlined in the brochure, be referred back to the Reference Committe on Reports of The Council.

E. D. SPALDING, M.D.: Is this an amendment to the amendment?

THE SPEAKER: No.

E. D. SPALDING, M.D.: There is a motion before the house.

THE SPEAKER: There is a motion before the house, which is in the form of an amendment. The motion to refer takes precedence over the motion to amend; therefore, the Chair feels that this could be referred back to the Reference Committee on Reports of The Council for further consideration.

Is there any further discussion on the motion to refer back to the Committee?

F. A. WEISER, M.D. (Wayne): I am in favor of the matter going back to Committee, but I feel very definitely that the House of Delegates should know why we oppose the present program.

We have a rather serious job ahead of us, and showing motion pictures to the populace at large isn't going to accomplish it. Putting advertisements in the newspapers isn't going to accomplish it.

I need not tell you what the method is going to have to be. It has been said here that we face a national plan by both parties, and I think anyone who runs may read them.

Let me cite a situation as indicative of what is going on: There is a county society in this State that invited, I believe, thirteen or fourteen political speakers to speak before them as they have previously done. This year, as of October 5, not one of these people accepted the invitation. I think that is rather significant. I don't think the politician wants to talk to a medical group at the present time, because something is coming. We are going to need money. We can't fritter it away on a public relations program that is aimed at glorifying the doctor. We need no glorification. Our work is our glorification, and if we need any beyond that, God help us!

Another point: Let's assume we do have the J. M. Handy Company make pictures for us—cinema, as it has been called. What is to prevent the cults from having a similar picture made? Do you think for a minute that J. M. Handy is going to turn down a group of cults that will pay them $12,000 for a picture? That's their business; sure, they'll make it! Are we going to start a race among cults for the visual education of the public? It just doesn't make sense, fellows!

If you recall Ed Sladek's talk yesterday, he gave us several instances of what we can do. What do you expect can overcome the feeling of the public when they are charged $6 for a doctor's signature on two marriage certificates? Can't you imagine that the people who know these things, when they see a picture of a doctor on a screen, pumped up as a pious, sanctimonious simp, say, "Oh, hell! A doctor is a human being!"? And that is what we are. Why should we try to put ourselves over on the public as something as sanctimonious as that shown in the picture, and as what will be shown and is, and what is being talked about over the radio?

We are almost always pictured as going out in the dead of the night, mushing through the snow, saving lives. Nothing is sillier; you and I know it.

The moment we begin to do honest public relations I will be for it. What I am for is to save our money. We are going to need it. Our public relations aren't going to be with the public in the movie theatres or at their fireside listening to the radio or reading the paper. Our public relations will have to be with those people who are controlling what is going to happen to organized medicine, and we should be for a plan equitable for the public and for us through legislation.

THE SPEAKER: Is there any further discussion to refer this section of the report back to the Reference Committee on Reports of The Council?

(The motion to refer was put to a vote and was carried, but not unanimously)

THE SPEAKER: The Chair believes that since an amendment was proposed to the report of the Reference Committee, and since that amendment has been referred back to the Reference Committee on Council Reports, it is impossible for the House to accept the report of The Council until it is reported out as amended.

Therefore, the Chair will ask that the Chairman of the Reference Committee on Council Reports will take back the entire report of The Council for discussion, and consider this amendment and report back at the next session. Are there any objections?

VIII—p. ON SEMI-ANNUAL MEETINGS OF THE HOUSE OF DELEGATES

A. H. KRETCHMAR, M.D. (Genesee):

"WHEREAS, the volume of business transacted by the House of Delegates of the Michigan State Medical Society has been increasing steadily during the past several years, and

"WHEREAS, the interval of time between annual sessions is often too long to give proper attention to the problems at hand, and

"WHEREAS, the Annual Michigan Postgraduate Institute meets during the spring months; therefore, be it

"RESOLVED: That henceforth a semi-annual meeting of the House of Delegates shall be held during the time of the Annual Postgraduate Clinical Institute, to transact such business and to consider such resolutions as may be presented at that time."

"In order to transact such business, and to consider any resolutions that may be presented; be it

"RESOLVEO: That a special meeting of the House of Delegates be called at the time of the meeting of the Michigan Postgraduate Clinical Institute for 1948."

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions.

T. K. GRUBER, M.D.: Mr. Speaker, I believe that will require an amendment to the By-Laws. I would suggest it be referred to the Reference Committee on Constitution and By-Laws.

"The House of Delegates shall meet annually at the time and place of the annual session, and may hold such other meetings of the House as it may determine or its business require."

THE SPEAKER: Dr. Gruber, the By-Laws may be amended on motion of the House without having to wait over a year, and the Speaker feels he would like to have the Committee on Resolutions consider this and report back at the next session. It would then be possible to have an opinion or motion by the Chairman of the Reference Committee on Amendments to the Constitution and By-Laws. However, this does not require an amendment.

Unless there is opinion expressed otherwise, the Chair would like to have this considered by the Reference Committee on Resolutions.

VIII—q. ON SALARY INCREASE TO MEDICAL OFFICERS IN ARMED FORCES

E. C. TEXTER, M.D. (Wayne):

"WHEREAS, the House of Delegates of the American Medical Association, at its meeting in Atlantic City, publicly announced a desire to elevate the standing of the general practitioner in the eyes of the lay public and the medical profession, and

"WHEREAS, the sentiment of all concerned at the Atlantic City meeting was to the effect that all doctors of medicine should have equal professional and financial opportunity regardless of what branch of the healing art they practiced, and

"WHEREAS, when a congressional bill was presented in which it was proposed that there be a differential in pay between so-called specialist officers and non-specialist officers in the military forces, the delegates contradicted their expressed views and approved this bill, and

"WHEREAS, the differentiation in rank and pay between these two groups in the recruiting of medical officers in the late war was one of the greatest sources of dissatisfaction, and

"WHEREAS, in peace time the military services have the time and finances to develop specialists among its various personnel at government expense in accordance with the ability shown; therefore, be it

"RESOLVED: That the American Academy of General Practice of Wayne County voice its approval of an increase in pay to medical officers of the armed services in general, but demand that no differentiation be made between so-called specialists and non-specialists; and be it further

"RESOLVEO: That a copy of this resolution asking for this approval be sent to the Board of Trustees of the American Medical Association, the Board of Directors of the American Academy of General Practitioners, the House of Delegates of the Michigan State Medical Society, and the Council of the Wayne County Medical Society."

THE SPEAKER: This resolution will be referred to the Reference Committee on Resolutions.

Are there any other resolutions?

W. B. MITCHELL, M.D.: There are a few resolutions here, Doctor, that we would like to take up. Before we do so, the Chairman of the Reference Committee on Reports of The Council would like to ask the Chair if he may have permission to find out just how many would like to attend the Committee meeting, and how large a room we will need for the meeting. How many would like to be at the Committee meeting? I think we had better use this room, Doctor. (Laughter)

THE SPEAKER: We will announce the room at the close of the meeting.

XII—b. RESOLUTION OF TENURE OF STATE HEALTH COMMISSIONER

W. B. MITCHELL, M.D.: The Committee has three resolutions to report on. The first is a resolution concerning Dr. DeKleine, presented by Dr. Bloemendaal of Ottawa County.

The Committee recommends that this resolution be not adopted. I so move.

L. G. CHRISTIAN, M.D.: I support the motion.

THE SPEAKER: It is moved and supported that this resolution be not adopted. Do you care to have the resolution read? It is requested that you read it. Will you read the "Resolved" part, Dr. Mitchell?

W. B. MITCHELL, M.D.:

"RESOLVEO: That the members of the Ottawa County Medical Society favor the continuance of Dr. William DeKleine as State Health Officer; and be it further

"RESOLVEO: That the delegate of the Ottawa County Medical Society be instructed to convey these sentiments to the House of Delegates convened at Grand Rapids, September 21-23, 1947."

D. C. BLOEMENOAAL, M.D.: That is not a resolution; it is just an expression of sentiment. We really don't have to take any action on it. I think you ought to read the entire resolution.

THE SPEAKER: Dr. Bloemendaal has asked that the entire resolution be read.

(Dr. Mitchell read the entire resolution)

THE SPEAKER: This resolution was presented. Action must be taken on every resolution. It is moved that this resolution be not adopted—in other words, be not approved.

S. L. LOUPEE, M.D.: If I heard that resolution correctly, we have no action whatever to take on the matter. Action has properly been taken. It has been presented to this group; we are through with it.

THE SPEAKER: The motion before the House is that this resolution be not adopted. Is there any further discussion?

R. S. BREAKEY, M.D.: I agree with Dr. Loupee. This is a resolution presented to us, and there is no request that we take any action *per se*. It has been read twice, and it says that Ottawa County Society took this action and instructed their delegate to read a record of their action into the minutes of this meeting. It does not request nor state that this House of Delegates take any such action.

This matter is one of some controversy, and you are either on one side or the other. Since this does not require us to take definite action, it would be a great deal more diplomatic if we received the resolution from Ottawa County and did not place ourselves in the embarrassing position of endorsing or not endorsing the now-existing Commissioner of Health.

THE SPEAKER: May the Chair suggest that Dr. Breakey move that the motion be laid on the table?

R. S. BREAKEY, M.D.: I should like to move that the resolution passed by the Ottawa County Medical Society be received.

THE SPEAKER: There is a motion on the floor that the resolution be not adopted. The Chair cannot accept your motion.

E. D. SPALDING, M.D.: I move that action on this motion be indefinitely postponed, which is a way of killing it without voting on it.

THE SPEAKER: The motion is that action on this motion be postponed indefinitely. Is there any discussion?

R. S. BREAKEY, M.D.: Yes. If there is a motion in order, I move that it be received.

THE SPEAKER: As a point of order, Dr. Breakey, it is not possible to move to receive it when a motion is on the floor. However, the motion to postpone action indefinitely takes precedence over the original motion. Therefore, the motion on the floor is to postpone indefinitely. It is supported by Dr. Weiser of Wayne County.

(The motion was put to a vote)

THE SPEAKER: The Chair asks for a division of the vote. Will the Secretary count the hands, please?

(The motion was carried, with four dissenting votes)

THE SPEAKER: The motion is carried, and action is delayed indefinitely.

XII—b. REPORT OF SPECIAL COMMITTEE ON THE STUDY OF MEDICAL PRACTICE ACT

W. B. MITCHELL, M.D.: This is a resolution concerning a report of a Special Committee on the Study of the Medical Practice Act. It is recommended by this Committee that the report made to The Council by the Special Committee to Study the Medical Practice Act be not presented to the House at this time, in view of the fact that the work is incomplete—that is, the work of the Committee of The Council is incomplete.

I so move.

R. A. JOHNSON, M.D. (Wayne): I second the motion.

THE SPEAKER: The motion is that the report be not presented to the House because the work of the Committee of The Council is incomplete at this time. Do I take it you mean you are recommending no action on this resolution?

W. B. MITCHELL, M.D.: Yes.

THE SPEAKER: Is there any discussion on this motion?

E. D. SPALDING, M.D.: Will it be referred back to the Committee for further consideration?

W. B. MITCHELL, M.D.: It won't be necessary.

THE SPEAKER: It would be possible to refer this back to any committee. Does anyone care to make a motion?

C. S. RATIGAN, M.D. (Wayne): I think this House of Delegates should be informed as to whether this Committee will be continued or not. It is an important enough subject for the delegates to know. Not to have any knowledge of the work to be done—at least they should have some assurance that the work is going to be continued.

THE SPEAKER: May I answer that question? That Committee is a committee of The Council, and its work will be continued. Is that right, Dr. Foster?

Is there any further discussion on the motion that no action be taken on this resolution?

(The motion was put to a vote and was carried unanimously)

XII—b. ON RATIO OF MEDICAL OFFICERS IN ARMED FORCES

W. B. MITCHELL, M.D.: A resolution concerning the reduction of the ratio of physicians to the personnel in the armed forces. It is recommended to the House of Delegates that this resolution be not adopted.

I so move.

C. I. OWEN, M.D.: I second the motion.

THE SPEAKER: Do you care to have the resolution read, or do you remember it? Could you summarize it so we will know what we are voting on, Dr. Mitchell?

(Dr. Mitchell read the entire resolution)

THE SPEAKER: The motion before the House is that this resolution be not adopted. Is there any further discussion?

H. H. RIECKER, M.D.: This resolution came from the Washtenaw County Medical Society. There was pretty thorough study given to it by the men returning from the armed forces, believing there was an excess of medical officers, and that a better distribution in the armed forces could have been made of the physicians in the armed forces, and that the ratio of 6.5 physicians per 1,000 was too high.

This ratio is set by Congress, by law; it is not set by the Surgeon General. In the Navy and Marine Corps the ratio achieved and used during the was was 4.3. In the Army it was about the same. I don't have the exact figure for the Army, but the ratio of 6.5 was never accomplished in the armed services, and a great many of the returning surgeons in the Army thought there was an excess of medical personnel. They would like to have this ratio reduced to about 3 per 1,000, because they feel there were too many doctors in the Army not being used.

This is their opinion, not mine; I am merely explaining the origin of this resolution. I have talked to a large number of returned Army doctors, and they all feel exactly the same. Dr. Coller, who had a great deal to do with relations in the Army in connection with physicians, felt this resolution was sound. All the men who had been in the armed forces believe this resolution is sound.

That is the background, Mr. Speaker. Thank you very much.

WILLIAM BROMME, M.D. (Wayne): This entire subject was the matter of deliberative action last year in the House of Delegates meeting, and a request for reviewal of the ratios for medical officers in the armed forces was concurred in by the House of Delegates and was transmitted by the executive officer. That request already is in the hands of the Department of War in Washington, and I believe there is no further reason for passing this.

THE SPEAKER: Dr. Bromme feels there is no further reason for taking up this subject. Is there further discussion on this motion?

VOICE: Why did they accept the air forces' figures?

THE SPEAKER: I might refer that question to Dr. Mitchell. Why did the air forces accept this? He doesn't know.

B. M. HARRIS, M.D.: There was a peculiar setup in the air forces. It may be necessary that they have more medical officers.

VOICE: For what reason?

B. M. HARRIS, M.D.: God only knows.

THE SPEAKER: Is there any further discussion on the motion that this resolution be not accepted?

T. K. GRUBER, M.D.: May I answer the question of why they need more in the air forces? They need more psychiatrists in the air forces. (Laughter)

THE SPEAKER: Is there any further discussion on the motion that this resolution be not accepted?

(The motion was put to a vote and was carried unanimously)

W. B. MITCHELL, M.D.: It is recommended that the general outlay of the complaints as enumerated by the Chairman of the Council in his report to the House of Delegates, regarding doctors of medicine, be taken back to the component Societies for discussion and consideration.

The Committee has reviewed the report of The Council and the supplemental report of The Council in detail, and takes this occasion to express its confidence and appreciation for the high caliber of work and the extraordinary devotion to duty by the members of The Council.

Mr. Speaker, I move that the report of the Committee as a whole, as amended, be adopted.

H. F. DIBBLE, M.D.: I second the motion.

(The motion was put to a vote and was carried unanimously)

W. B. MITCHELL, M.D.: May I please announce that right after this meeting, in Room 222, we will have a meeting of this Committee. All those who are interested in voicing an opinion will please be there and help us. Thank you.

THE SPEAKER: Dr. Foster has a short announcement.

THE SECRETARY: We have with us in the back of tbe room, available to anyone, the official photographer of the American Medical Association, who has taken all the individual pictures for the AMA and various state medical societies tbroughout the country. He is set up in back for anyone who chooses to have a personal photograph made.

THE SPEAKER: While Dr. Gruber goes back to have his picture taken, we will proceed. (Laughter)

XII—c. ON STANDING COMMITTEES

The next item of business is the report of the Reference Committee on Standing Committees.

WILLIAM BROMME, M.D.: This Committee has the function of reviewing the reports of sixteen standing committees of the Society.

XII—c. LEGISLATIVE COMMITTEE

First, your Committee recommends that the report of the Legislative Committee be adopted.

I so move.

R. V. WALKER, M.D. (Wayne): Second the motion.

(The motion was put to a vote and was carried unanimously)

XII—c. COMMITTEE ON DISTRIBUTION OF MEDICAL CARE

WILLIAM BROMME, M.D.: We recommend that the report of the Committee on Distribution of Medical Care be adopted and I so move.

DOUGLAS DONALD, M.D. (Wayne): Support.

(The motion was put to a vote and was carried unanimously)

XII—c. MEDICAL LEGAL COMMITTEE

WILLIAM BROMME, M.D.: We recommend that the report of the Medical Legal Committee be adopted, and I so move.

L. W. HULL, M.D. (Wayne): I second the motion.

(The motion was put to a vote and was carried unanimously)

XII—c. PREVENTIVE MEDICINE COMMITTEE

WILLIAM BROMME, M.D.: We recommend that the report of the Preventive Medicine Committee be adopted, and I so move.

R. A. SPRINGER, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously)

XII—c. CANCER COMMITTEE

WILLIAM BROMME, M.D.: Your Committee recommends that the report of the Cancer Committee be adopted, but we urge the Cancer Detection Clinics to realize that the clinics are detection clinics and not one to treat cases. I so move.

M. A. DARLING, M.D. (Wayne): Second the motion.

S. L. LOUPEE, M.D.: I would like to have someone in this group outline for us what the purposes of this Cancer Committee are.

THE SPEAKER: Would you like to call on anyone, Dr. Loupee?

S. L. LOUPEE, M.D.: Who is the chairman of that committee?

THE SPEAKER: Dr. Norman Miller, of Ann Arbor. I am sorry he is not here.

S. L. LOUPEE, M.D.: Is there anyone here who serves on that Committee?

THE SPEAKER: Is there anyone here to answer Dr. Loupee's question?

S. L. LOUPEE, M.D.: Is it scientific? Is it economic? Is it political, or what? I would like to know.

THE SPEAKER: Is there anyone here who cares to answer that question?

F. L. RECTOR, M.D. (Ann Arbor); I happen to be the secretary of the Cancer Control Committee.

The Cancer Control Committee of the Michigan State Medical Society in the last year, under the wise suggestion of Dr. Hyland, was enlarged to incorporate in its activities the work of all the institutions and organizations in the state interested in cancer control. That included primarily the three organizations, the Michigan Division of the American Cancer Society, the State Department of Health, and the Michigan State Medical Society. This made a Committee of approximately twenty-five members.

In order to emphasize the work, Dr. Miller, the Chairman, appointed three subcommittees which he entitled the Subcommittee on Education, the Subcommittee on Ways and Means, and the Subcommittee on Fact Finding.

The Subcommittee on Education has, as its title indicates, the responsibility of being in charge of the educational work in the state, for which the Committee is primarily responsible. The Michigan Cancer Bulletin, which you are receiving at the present time, having received six of the thirteen issues to date, is one expression of the work of that Subcommittee. A Speakers' Bureau of some sixty members, well distributed over the state, was also set up, each member indicating his willingness to speak on cancer subjects before lay and other audiences. A set of newspaper articles that is being published serially was also set up by this Subcommittee on Education.

The Subcommittee on Education further tried to interest local medical societies in holding special cancer programs, and in certain instances holding what we call cancer teaching day programs, where they will devote a whole day and evening to the subject of cancer education for the profession, under the auspices of local

organizations. Several of those meetings have been held in the past year, and others are in process of being held in the months ahead. Those are examples of the work of the Subcommittee on Education.

The Subcommittee on Ways and Means has not been as active up to this time as it is expected it will be in the future. Its primary function is to consider the financial problems of the cancer control movement. As you know, very greatly increased amounts of money are being made available for the control of cancer, both from private and from public sources.

Last year the Public Health Service distributed 2½ million dollars throughout this country to the various state health departments for cancer control work. Some $84,000 of that came to Michigan. This year, I understand, an equal or possibly greater amount of money is available. The American Cancer Society in 1946 collected something like $11,000,000, and this year they collected over $12,000,000. That made a total of money available in Michigan for cancer control well over $350,000. It was felt that there should be some committee of responsibility concerned in the expenditure of those funds, and that is what the Ways and Means Committee is primarily intending to do.

Third, we have the Committee on Fact Finding which has set for itself two important pieces of work that are being carried out at the present time under the control of the committee. One of those is a survey of the hospital facilities in Michigan, a request having been sent to all hospitals of twenty-five beds or over, asking for information about their capacity to care for patients, their facilities for the diagnosis and treatment of cancer, and also their experience with cancer during the previous year, as to how many kinds of patients they had, and information of that sort.

The other survey or study is what we call a pilot study that has been carried out in four areas of the State, one of those being Hillsdale County, another Kent County (where we now are), a third a three-county district consisting of Antrim, Charlevoix and Emmett County upstate, and another, Baraga, Houghton and Keweenaw Counties in the Upper Peninsula.

Those surveys have been carried out by senior medical students who have been trained to gather the information requested, and that information has consisted in obtaining definite information about all cancer patients seen by physicians in those four areas or treated in the hospitals of those four areas during the year 1946.

The purpose of this survey was to find out primarily how many cancer patients there were known to the medical profession and the hospitals in those four areas in 1946. In other words, an incidence study, something we have never had before in the State of Michigan.

We also wanted to know how much cancer there was in the county known to the profession, a prevalence study, so called. We wanted to know how those patients had been taken care of, what had been the result of their treatment, and similar information. That information was gathered in such a way that it can be studied statistically, and that work closed just last week. Those case histories, of which there are hundreds, as soon as possible will be subjected to careful statistical analysis, and that information will be made available, of course, to the profession and to the state at large.

Out of these surveys it is hoped that there will come a better program and a more intelligent program for the care of cancer patients in this state.

During the coming year it is proposed that that program shall be extended. It is hoped and expected that the Michigan Cancer Bulletin, when the thirteen issues have been distributed, will probably be continued in some similar fashion. That method has not yet been definitely determined. It is also hoped and expected that the Speakers' Bureau will be enlarged and its services extended. In other words, we hope and plan to continue along the lines that have been followed during the past year.

Mr. Speaker, if there are any other questions I would like to try to answer them.

THE SPEAKER: The motion before the House is to accept the report of the Committee.

S. L. LOUPEE, M.D.: Mr. Speaker, I want to thank Dr. Rector for answering my question so completely. If it is permissible I would like to have an answer to another question:

Is any of this effort being expended in the hope that the cause of cancer will be determined and that the number of cases will ultimately be curtailed, Dr. Rector?

THE SPEAKER: Dr. Rector, would you like to answer that question? The question is whether any of the money is being spent with the hope that the cause of cancer will be detected and the number of cases curtailed.

F. L. RECTOR, M.D.: One thing I did not say was that this question of cancer detection clinics has that very purpose in mind. The Committee, of course, has always recommended that these clinics be established only upon the recommendation and with the full approval and consent of the county medical society in which they are established.

The Committee believes very definitely, I think, although I cannot speak for each and every member of it, that cancer detection clinics are simply one step toward the development of a better service to the cancer patient in order to cut down the rapidly mounting number of deaths from cancer.

We haven't much hope of stopping or preventing the development of cancer, but it has very definitely become established that when you can get cancer in early stages there is a very definite hope and possibility of curing that patient and preventing his death from cancer. And so the work of the Committee, of course, is directed toward the very broad objective of reducing the number of deaths from cancer in this state.

I would like to say this about cancer detection clinics: While there seems to be some objection to them on the ground that the conduct of these clinics requires a great deal of work for the number of cancer patients found, and it has been found that only from 1 to 2 per cent of the people examined have cancer, it has also been found that from 40 to 60 or 80 per cent of those people who are examined are in need of medical attention for conditions other than cancer; and when a clinic is properly conducted those patients are immediately referred back to their family doctor for care for those conditions. In that way I think you can see that a very fine program of preventive medicine is being inaugurated through these cancer clinics.

E. D. SPALDING, M.D.: That is good public relations.

THE SPEAKER: The Chair would like to call on Secretary Foster for a remark about a report rendered by the Cancer Committee to The Council.

THE SECRETARY: The minutes of The Council have not been transcribed, but my recollection is that yesterday in the report of the Cancer Committee there was a very definite statement made describing the technique to be used in the cancer detection clinics. It involved the question of economic status of individuals, and primarily was based upon the fact that no cancer detection clinic should be established anywhere without the consent of the local county medical society.

THE SPEAKER: Is there any further discussion on the motion that the report of the Committee be accepted, with the suggestions of the Reference Committee?

(The motion was put to a vote and was carried unanimously)

XII—c. MATERNAL HEALTH COMMITTEE

WILLIAM BROMME, M.D.: We have no report from the Maternal Health Committee for 1946-47.

XII—c. VENEREAL DISEASE CONTROL

We recommend that the Committee on Venereal Disease Control be adopted, and I so move.

R. L. WADE, M.D. (Branch): Second the motion.

(The motion was put to a vote and was carried unanimously)

XII—c. TUBERCULOSIS CONTROL

WILLIAM BROMME, M.D.: We recommend that the report of the Committee on Tuberculosis Control be adopted, and I so move.

C. W. OAKES, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously)

XII—c. INDUSTRIAL HEALTH COMMITTEE

WILLIAM BROMME, M.D.: The Committee on Industrial Health had no formal meeting. We recommend that this report of the Committee be adopted, but suggest that in view of the fact that Michigan is a highly industrial state, it would seem that this Committee should be more active.

I move adoption of the report.

R. A. SPRINGER, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously)

XII—c. MENTAL HYGIENE COMMITTEE

WILLIAM BROMME, M.D.: We recommend that the report of the Committee on Mental Hygiene, as supplemented by remarks from Dr. Henry Luce on September 21, 1947, be adopted. We recommend further that the Executive Committee of The Council reconsider the request for allocation of space for an advisory clinic.

I move that these recommendations be adopted.

E. C. TEXTER, M.D.: I second the motion.

(The motion was put to a vote and was carried unanimously)

XII—c. CHILD WELFARE COMMITTEE

WILLIAM BROMME, M.D.: We recommend the adoption of the report of the Child Welfare Commission, and I so move.

C. S. RATIGAN, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously)

XII—c. IODIZED SALT COMMITTEE

WILLIAM BROMME, M.D.: We recommend the adoption of the report of the Committee on Iodized Salt, and I so move.

R. S. BREAKEY, M.D.: I second the motion.

(The motion was put to a vote and was carried unanimously)

XII—c. HEART AND DEGENERATIVE DISEASES

WILLIAM BROMME, M.D.: We recommend the adoption of the report of the Committee on Heart and Degenerative Diseases. I so move.

HARRY LIEFFERS, M.D. (Kent): I second the motion.

(The motion was put to a vote and was carried unanimously)

XII—c. COMMITTEE ON POSTGRADUATE EDUCATION

WILLIAM BROMME, M.D.: We recommend the adoption of the report of the Committee on Postgraduate Medical Education. We commend all who participated in this expanding program.

I move that the recommendation be adopted.

E. D. SPALDING, M.D.: I second the motion.

(The motion was put to a vote and was carried unanimously)

XII—c. ETHICS COMMITTEE

WILLIAM BROMME, M.D.: We recommend the adoption of the report of the Ethics Committee, and I so move.

B. M. HARRIS, M.D.: Second.

(The motion was put to a vote and was carried unanimously)

XII—c. PUBLIC RELATIONS COMMITTEE

William Bromme, M.D.: We recommend the adoption of the report of the Public Relations Committee for 1946-47, with the following suggestions:

(a) We recommend that extensive consultation be employed before media such as the cinema (displayed as a supplemental report by Dr. Walls) are utilized.

(b) Based upon the report of the Chairman of The Council which illustrated specific instances of poor relations between physicians and their patients, we recommend that this important element in public relations be added to the public relations program.

Mr. Speaker, I move the adoption of both these recommendations and of the report of the Committee.

The Speaker: It is moved that the report of the Public Relations Committee be adopted, with the specific recommendations on consultation on the cinema and emphasis on personal relationships throughout the State. Is there a second to the motion, gentlemen?

C. L. Weston, M.D. (Shiawassee): Second the motion.

E. D. Spalding, M.D.: Mr. Chairman, in view of the fact that this and related matters have been already referred back to Reference Committee on Reports of The Council, would it not be wise to postpone final action on this until we again hear from the Reference Committee?

The Speaker: Do you care to make a motion?

E. D. Spalding, M.D.: I will move that action on this be postponed pending the final report from the Reference Committee.

W. W. Babcock, M.D.: I second the motion.

H. H. Riecker, M.D.: Is that an amendment?

The Speaker: No; this takes priority over Dr. Bromme's motion. We can decide to delay action on this pending another report. In other words, we are postponing it to a specific time.

(The motion was put to a vote and was carried unanimously)

William Bromme, M.D.: Mr. Speaker, I recommend the adoption of the report of this Reference Committee on Reports of Standing Committees as accepted serially, with the exception of the report of the public relations program, as just postponed.

R. A. Johnson, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously)

The Speaker: Thank you, Dr. Bromme, for your hard work.

XII—d. ON REPORTS OF SPECIAL COMMITTEES

The next item on the agenda is the report of special committees. We are going to try to cover as much of this as we can until we get too hungry. I will call on Dr. Gerstner of Kalamazoo County to render this report.

L. W. Gerstner, M.D. (Kalamazoo):

XII—d. NURSES TRAINING SCHOOLS

The first report is that with reference to the Committee on Nurses Training Schools. The Committee moves the adoption of the report and the supplemental report, with the suggestion that further thought be given to locating training centers in areas of the state not served by centers that have been suggested. The program should be expanded to fill a need in rural communities where facilities are available to start additional schools.

To clarify that, the program on nurses' training includes the training of nurses' assistants throughout various communities of the State, and it was the opinion of the Committee that more communities should be served by those training centers; that is, where a community is equipped to have such training we felt a training center should be established there if indicated.

I move the adoption of this part of the report.

R. L. Wade, M.D.: I second the motion.

(The motion was put to a vote and was carried unanimously)

The Speaker: The Chair will request that if there are no particular additions or suggestions, you read the names of these Committees and we will adopt them in a group, until you find one which is controversial.

XII—d. SCIENTIFIC RADIO

L. W. Gerstner, M.D.: The report of the Scientific Radio Committee has been approved.

XII—d. WOMAN'S AUXILIARY

There was no report from the Advisory Committee to Woman's Auxiliary.

XII—d. SCIENTIFIC WORK

The report of the Scientific Work Committee is approved. The Committee commends them for the splendid program they have arranged.

XII—d. PROFESSIONAL LIAISON COMMITTEE

The report of the Professional Liaison Committee was approved. We believe the function of this Committee can be carried on by the revitalized Health Committee, and recommend that the Professional Liaison Committee be discontinued.

I so move.

H. F. Dibble, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously)

XII—d. BEAUMONT MEMORIAL COMMITTEE

L. W. Gerstner, M.D.: The report of the Beaumont Memorial Committee is approved.

XII—d. SPECIAL COMMITTEE ON RADIO

The report of the Special Committee on Radio is approved.

XII—d. POSTWAR EDUCATION

The report of the Committee on Postwar Education is approved, and the Committee advises that this Committee be discontinued, as recommended by their Chairman.

I so move.

W. W. Babcock, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously)

XII—d. RHEUMATIC FEVER

L. W. Gerstner, M.D.: On the report of the Committee on Rheumatic Fever Control, the Reference Committee wishes to commend Dr. Riecker and his Committee for the magnificent work done the past year in establishing both study of rheumatic fever and the furthering of education to both doctors and lay groups. The Committee recommends that paragraph C of the Annual Report be deleted, and as a substitute paragraph C the Committee recommends that any follow-up of cases be carried out by or through the approval of the family physician.

With these suggestions and deletions, I move the adoption of this report, except that I note there is a typographical error in that report. In the third paragraph they speak of the women's fraternity alumni association, and they meant sorority, which obviously should be corrected.

R. A. Springer, M.D.: I second the motion.

H. H. Riecker, M.D.: May I discuss that objection for a moment?

Gentlemen, there is no sinister implication in paragraph C. I was amazed that my Central Committee was so enthusiastic about the willingness of the Alpha Phi Sorority to accept their help in this work with local committees.

Suppose a woman wants to help the Committee. They want to follow up a case and they want to know for certain that a child is receiving prophylactic treatment. An intelligent, thoroughly trained woman can go out to a community in an isolated area and see the family in the home, and can report back to the doctor or the Committee. The local committee is responsible to the physician.

There is nothing sinister about this. I don't think there should be any objection to it. We are trying to co-operate with interested lay groups. The whole Committee feels that way about it. I would like to have Dr. Gerstner's Committee approve the supplemental report, and reject their criticism of paragraph C. It has nothing but an innocent meaning of co-operation with any people who can help the doctor and the diagnostic groups in local centers which are controlled and appointed by the county societies.

The Speaker: Thank you, Dr. Riecker. Do we all know what we are discussing? I will ask Dr. Gerstner to read paragraph C, which appears to be controversial again.

L. W. Gerstner, M.D.: Paragraph C has not been read here; I shall read it now: "Qualified individuals would be welcomed to assist the public health nurses in follow-up of cases under the direction of the diagnostic group."

The Committee is well aware of the intent of this paragraph. It was established that cases could be followed, as they would have to be if the rheumatic fever clinics are to function adequately. However, it was also felt that any follow-up of these patients should be done through the family physician only, that by sending out any lay groups or public health nurses to the home we would be going around the family physician, and we felt there would be a happier feeling among the physicians themselves if that paragraph were deleted.

The Speaker: Will you read your recommendation on that paragraph now, Doctor?

L. W. Gerstner, M.D.: "The Committee recommends that paragraph C of the Annual Report be deleted, and as a substitute paragraph C the Committee recommends that any follow-up of cases be carried out by or through the approval of the family physician."

That would then permit the same people to make the follow-up, but it would be through the family physician rather than through the diagnostic center as such.

The Speaker: The motion is that the report of the Rheumatic Fever Committee as amended by the Reference Committee be adopted. Is there any further discussion?

H. H. Riecker, M.D.: May I discuss it further? I resent very thoroughly this implication that we are employing people outside of the doctor's realm. I want it thoroughly understood that I resent this very much. The whole committee has worked consistently through the family physician. That is our policy. I emphasized it yesterday.

There is nothing sinister about paragraph C. If, in an isolated community in the northern peninsula, Dr. Cooperstock could send out some educated layman to see that a child is receiving proper nutrition, that it is receiving its medication, that all the other children in the family are not living in the same room and sleeping five in a bed—it is in our minutes that this can be done in certain areas. There is no sinister implication about using public health nurses to co-operate with the doctors. Why not use them if they are needed and if they can do it? I resent very much that this has come up, because, as Dr. Foster can substantiate, all our effort has been that we have not in any sense turned the control of rheumatic fever over to people other than the family physicians in co-operation with the diagnostic centers, which are really those physicians.

I would rather have you reject the whole report and the supplementary report than to criticize this Committee and our subcommittees who have worked so hellishly hard to set up this program.

R. H. Denham, M.D.: It seems to me these qualified individuals are simply going to do social service work, and as such will not interfere with the follow-up of the physician.

H. H. Riecker, M.D.: That is exactly right.

The Speaker: The revised addition of the report states "that any follow-up cases be carried out by and through the approval of the family physician," which certainly allows the same technique to be carried out. It also says, "We wish to commend Dr. Riecker and his Committee for the magnificent work done during the past year."

The motion is that we accept the report as amended by the Reference Committee. Are there any other remarks?

(The motion was put to a vote)

The Speaker: The Chair asks for a division of the vote.

(By hand vote the motion to accept the report as amended was carried by 42 to 17)

The Speaker: The motion in favor of the acceptance of this report as amended is passed.

The Chair would like to point out that he does not feel this is any indictment of the Committee. It is complimentary to the Committee, and certainly the thing will work out as it always has.

L. W. Gerstner, M.D.: I would like to confirm what has just been said regarding the action just taken. Certainly there is no one on the Committee who would not compliment to the highest degree Dr. Riecker and his Committee. Obviously it also is not the personal opinion of the Chair alone that formed the suggestion.

XII—d. CONTACT COMMITTEE WITH ASSOCIATION OF WELFARE BOARDS AND BOARDS OF SUPERVISORS

The report of the Committee on Association of Welfare Boards and Boards of Supervisors is recommended.

XII—d. VETERANS AFFAIRS

On the report of the Committee on State Veterans Affairs, the Committee moves the adoption of the report and recommends that the Committee assume the function of the Committee on Postwar Education.

I so move.

Harry Lieffers, M.D.: I second the motion.

(The motion was put to a vote and was carried unanimously)

XII—d. COMMITTEE ON INFECTIOUS DIARRHEA

L. W. Gerstner, M.D.: The report of the Joint Committee on Infectious Diarrhea is recommended.

XII—d. UNIFORM FEE SCHEDULE

The report of the Special Committee on Uniform Fee Schedule for Governmental Agencies is approved.

XII—d. RURAL HEALTH COMMITTEE

The report of the Committee on Rural Health is approved, and the Reference Committee highly commends the Committee on Rural Health.

XII—d. COURSES IN MEDICAL ECONOMICS

The report of the Committee on Courses in Medical Economics is approved.

I move that these reports be approved.

R. A. Johnson, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously)

XII—d. COMMITTEE ON MICHIGAN HIGH SCHOOL ATHLETIC ACCIDENT BENEFIT FUND

L. W. Gerstner, M.D.: The report of the Committee on Michigan High School Athletic Accident Benefit Fund: The Reference Committee commends the work of the Committee but disagrees with its recommendations. We recommend that doctors take care of accidents for no less than a minimum fee, as set up for governmental agencies.

I move the acceptance of this report as amended.

R. L. Wade, M.D.: Second the motion.

The Secretary: May I discuss this? I don't see the Chairman of the Committee here.

In connection with that amendment I would like to say that the Committee has been working with the Director of Interscholastic Athletics, and they have under consideration at the present time the subject he has brought up, about the governmental agency fee schedule.

However, this again is a question of public relations, and it has been pointed out in various comments that one of the finest gestures is the participation in this until such time as the schedule of benefits as set up can be revised upward, but that in the meantime something be done in the way of participation with this group.

The present fee schedule as paid by the student to the schools is not sufficient to meet the uniform fee schedule at this time. However, the Committee has had several meetings during the year that I know of, in which that very point was under consideration with the Administrative Committee of the Interscholastic Athletic group. It was felt that right now, and during this transition period of discussion, any attempt to throw down this program of the high school students would be anything but good public relations.

T. K. Gruber, M.D.: Mr. Speaker, I heartily agree with what Dr. Foster just said. If you will note in the press from time to time, Mr. Briggs in Detroit has groups of children, boys and girls, go to the ballgames free of charge. He is running a good public relations proposition of training the boys and girls to go to ballgames so when they grow up they will go and pay for it.

If a doctor wants to go into a high school or any school and present his proposition, he certainly wants the friendship of the boys and girls in that school. Maybe he won't get full price for it, but after all he has to pay something for advertising.

It seems to me it is a very fine way to contact the youth of the country and have them say, "Doc's a fine guy, and we're for him," whereas if you say "We are going to exact the last dime," they may say, "We're kind of sore at him."

I think what Dr. Foster said is very pertinent. (Applause)

The Speaker: Dr. Gruber, there is one sentence in here with which you disagree. It says, "We recommend that doctors take care of accidents for no less than the minimum fee as set up for governmental agencies." Do you care to move an amendment to get this off the floor? There is a motion on the floor that the report be accepted with this recommendation.

T. K. Gruber, M.D.: I would move that this recommendation be deleted; I so amend the motion, that that be taken out.

W. W. Babcock, M.D.: Support.

The Speaker: The amendment is that we amend the motion to strike out this recommendation.

(The amendment was put to a vote and was carried unanimously)

XII—d. NATIONAL EMERGENCY SERVICE

L. W. Gerstner, M.D.: The report of the Committee on National Emergency Service is recommended approved.

XII—d. COMMITTEE TO MEET CONGRESSMEN

The report of the Special Committee to Meet Congressmen was accepted. The Reference Committee believes this was an effective piece of public relations and the move should be repeated.

XII—d. INDUSTRIAL STUDY COMMITTEE

The report of the Industrial Study Committee is recommended as printed.

I move that these reports be accepted.

H. F. Dibble, M.D.: Support.

(The motion was put to a vote and was carried unanimously)

L. W. Gerstner, M.D.: I move the adoption of the report of the Reference Committee as a whole, with the deletions as amended.

E. A. Oakes, M.D. (Manistee): Second the motion.

(The motion was put to a vote and was carried unanimously)

The Speaker: Thank you very much, Dr. Gerstner.

XII—e. ON CONSTITUTION AND BY-LAWS

The next order of business is the report of the Reference Committee on Constitution and By-Laws.

R. A. Johnson, M.D.: Mr. Speaker, there are two resolutions asking for the establishment of two Sections.

XII—e. SECTION ON PUBLIC HEALTH & PREVENTIVE MEDICINE

The first is that a Section on Public Health and Preventive Medicine be established. The Committee recommends this be done. I move the adoption of this resolution.

R. V. Walker, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously)

XII—e. SECTION ON NERVOUS AND MENTAL DISEASES

R. A. Johnson, M.D.: A similar resolution has to do with the establishment of a Section on Nervous and Mental Diseases. The Committee recommends the adoption of this resolution, and I so move.

C. W. Oakes, M.D.: I second the motion.

(The motion was put to a vote and was carried unanimously)

XII—e. AMENDMENTS TO CONSTITUTION PROPOSED IN 1946

R. A. Johnson, M.D.: There were two items left over from last year on the amendment to the Constitution having to do with emeritus membership and life membership. The Committee recommends that the present wording regarding emeritus membership be maintained as it now appears in the Constitution and By-Laws. I move the adoption of this recommendation.

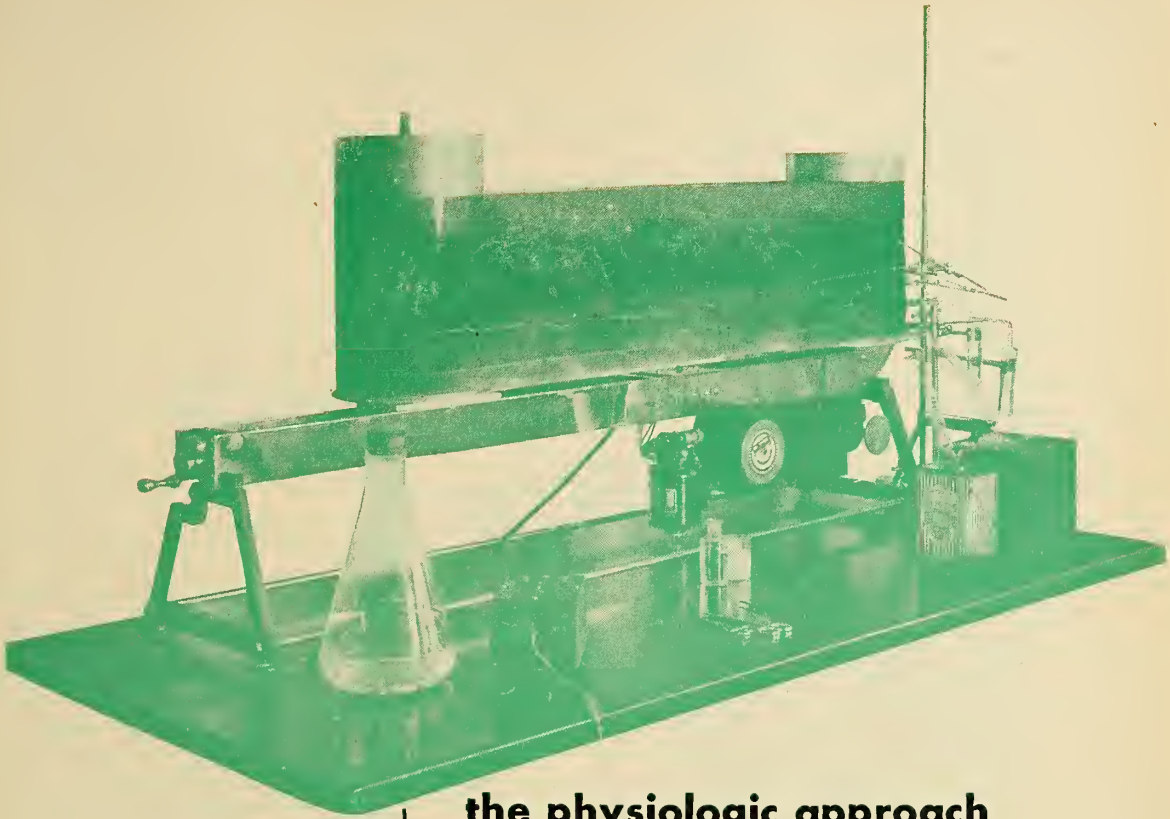
The Speaker: You have heard the recommendation that this amendment to the Constitution be not adopted.

E. C. Texter, M.D.: Second the motion.

Voice: Will you read the amendment, please?

R. A. Johnson, M.D.: (Art. III—Sec. 6) "Member Emeritus: Any physician who has been in practice fifty years, or has attained the age of seventy years, and who has maintained a membership in good standing for twenty-five years may, upon written application and upon recommendation of his county society, and by election in the House of Delegates, became a member emeritus.

(Continued on Page 1322)



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SEARLE

Research in the Service of Medicine

(Continued from Page 1320)

A member emeritus shall be required to pay annual dues to the State Society not in excess of $10 and be relieved of paying all assessments. He shall be entitled to all the benefits and privileges of membership."

R. H. Denham, M.D.: It strikes me that for a man to have to make a signed application at the age of seventy, after having practiced for twenty-five consecutive years, is unreasonable. When we confer an honor upon these men I don't think it should be incumbent that they make application for that honor—if it is an honor. I would like to see that clause stricken which requires a written application being made.

The Speaker: May I ask the Chairman of the Committee to read the recommendation of the Committee again, in order that we all understand it?

T. K. Gruber, M.D.: What is the recommendation? Is it on Section VIII?

R. A. Johnson, M.D.: The recommendation is that the status of emeritus membership be not changed, and be continued as it now appears in the Constitution.

The Speaker: In other words, Dr. Johnson, you are recommending that this proposed amendment be not adopted?

R. A. Johnson, M.D.: That is correct.

(The motion was put to a vote and was carried unanimously)

R. A. Johnson, M.D.: The Committee recommends that there be changes in the present wording regarding life membership. The Committee proposes, under Article III, Section 8, the word "twenty-five" be substituted for the word "ten" on the third line, and between the word "upon" and "application" in the fourth line, these words be inserted: "his personally signed."

The amended resolution would read as follows: "A physician who has attained the age of seventy years or more, and maintained an active membership in good standing for twenty-five years or more in his State Society, may, upon his personally signed application and recommendation of the county society, be transferred to life member roster by election in the House of Delegates. He shall have the right to vote and hold office, but shall pay no dues to the State Society. Request for transfer shall be accompanied by certification by the Secretary of the State Society as to years of membership in good standing."

I move the adoption of the amendment as read.

Harry Lieffers, M.D.: I second the motion.

The Speaker: As a technical point, Dr. Johnson, is it the amendment proposed last year and which appeared on the pages of The Journal?

R. A. Johnson, M.D.: Not quite. The Committee has reworded the proposal as it was handed to us.

The Speaker: The Constitution calls for the necessity of presenting any proposed amendment to the Constitution at one session, having it lie over for a year, during which time it must be published in the pages of The Journal. If the intent of the amendment has not been changed by the Committee, the Chair believes it is right and proper to vote on it at the present time.

Is there any further discussion?

F. G. Buesser, M.D. (Wayne): May I ask whether or not the wording of this should be changed so that a man shall pay no dues or assessment?

The Speaker: Dr. Johnson, what is the opinion of the Committee with regard to dues and assessments of life members?

R. A. Johnson, M.D.: Thank you, Dr. Buesser; that is an oversight. "Should not be paid by life members, nor should dues."

The Speaker: Will you read this as it will appear, then? Do you have the word "assessments" in there?

R. A. Johnson, M.D.: I didn't have it in, but it should be in.

The Speaker: The Committee decided it should be in?

R. A. Johnson, M.D.: That is correct.

C. S. Clarke, M.D. (Jackson): I would like to ask if it means twenty-five continuous years, or any twenty-five years, and whether he must be active at the time of application?

R. A. Johnson, M.D.: That is a good point, and a bugbear in the Committee. The thought was to have it twenty-five consecutive years; but, after all, one year follows another, and if you say "consecutive" you must say "consecutive active membership years." That will work a hardship on the group who may be on the retired list for a few years. After all, if a member has been in good standing for twenty-five years, the intent of the honor of life membership is there and is implied. I don't know of any better language than that which now appears in our Handbook on that point.

C. S. Clarke, M.D.: May I add one thing: There is at least one county that has paid the dues of one of their men whom they have been trying to put on the life membership list, paying it out of their own treasury. Is that necessary under the proposal?

The Speaker: Dr. Johnson doesn't choose to answer that question. I believe it has been held that if an application comes from a man who is not a member in good standing, that application is not honored; is that right, Dr. Foster? A man must have paid his dues up until the time the application is made?

The Secretary: It has been ruled that a man must be in good standing at the time of his application.

The Speaker: Therefore, if you pay this man's dues up until the time he is eligible, his application will be honored.

T. K. Gruber, M.D.: Mr. Speaker, I wonder if they even have to pay his dues. If he has not been able to practice or pay his dues, he could be made a retired member; if a retired member, he is in good standing. Therefore, if a man was sick for five years and was on the retired list, and then practiced for five years and then was sick for five years and was well for fifteen years, that would be twenty-five years of good standing.

The Speaker: Any further discussion on the amendment? If not, the Chair will ask for a vote by a show of hands. This is necessary, gentlemen, because it requires a two-thirds vote to amend the Constitution.

(The motion was put to a vote and was carried unanimously)

R. A. Johnson, M.D.: I merely wish to announce that there are proposed changes in the Constitution and By-Laws as outlined by Dr. Gruber, upon which of course this Committee cannot take any action.

I move the approval of the report of the Committee as a whole.

E. C. Texter, M.D.: I second the motion.

(The motion was put to a vote and was carried unanimously)

The Speaker: The next item of business is the report of the Reference Committee on Resolutions. Dr. Breakey.

R. S. Breakey, M.D.: I move, Mr. Speaker, that the report of the Reference Committee on Resolutions be postponed to become the first order on the agenda at the session this evening.

(The motion was severally seconded, put to a vote, and carried, and the meeting recessed at 12:30 p.m.)

(To be concluded in December issue)

MEDICAL TREATMENT OF PERFORATED PEPTIC ULCER

(Continued from Page 1285)

References

1. Blackford, John M.: Panel discussion on peptic ulcer. J.A.M.A., 120:825, (Nov. 14) 1942.
2. Bloomfield, A. L.: The indications for operation in cases of peptic ulcer from the internist's point of view. Surgery, 17: 692, (May) 1945.
3. DeBakey, M.: Acute perforated gastro-duodenal ulceration; statistical analysis and review of literature. Surgery, 8:852, (Nov.) 1940.
4. Graham, Roscoe R. and Tovee, E. B.: The treatment of perforated ulcers. Surgery, 17:704, (May) 1945.
5. Hadley, H. G.: Perforated peptic ulcer and recovery without operation. Virginia M. Monthly, 67:697, (Nov.) 1940.
6. Lane, J. D. (senior surgeon, USPHS): Series to be published.
7. Martz, H. and Foote, M. N.: Analysis of 50 cases of perforated peptic ulcer, Surgery, 48:634, (June) 1940.
8. McCarthy, A. M., and Knoepp, L. F.: Perforated peptic ulcer. Am. J. Surg., 71:260, (Feb.) 1946.
9. Nagle, P.: Non-operative treatment of perforated gastric ulcer with generalized peritonitis by continuous gastric siphonage. Surgery, 4:687, (Nov.) 1938.
10. Paine, J. R. and Rigler, L. G.: Pneumoperitoneum in perforations of the gastro-intestinal tract. Surgery, 3:351, (March) 1938.
11. Singer, H. A.: Spontaneous recovery from perforation of peptic ulcer into free abdominal cavity. Arch. Int. Med., 45: 926, (June) 1930.
12. Thompson, H. L.: Acute perforation of peptic ulcer; immediate and late results in 500 cases. J.A.M.A., 113:2015, (Dec. 2) 1939.
13. Wangensteen, O. H.: Non-operative treatment of localized perforations of the duodenum. Minnesota Med., 18:477, (July) 1935.

AN EXPENSIVE "GIFT"

The Grandville Rotary Club heard a thought-provoking talk recently on "socialized medicine." It was given by a medical man who had made an intensive study of the subject.

He made the assertion that dictators since the time of Bismarck have gained control by promising all things to all persons.

(By the way, Peron, in Argentina, now is promising "socialized medicine.")

One of the deceptive aspects of the administration-sponsored measure before Congress is the impression given the average man that the medical service it would provide would be "free."

But would it be free?

A representative of the Actuarial Society of America recently analyzed the proposed national compulsory health insurance bill, as it is officially designated, and came to the conclusion that the system would cost 8 to 10 per cent of the entire payroll of the people covered.

Here's one "gift horse" we all should look in the mouth—before it bites us in the pocketbook.

—Reprint from editorial by John M. Kelly, *The Star and Alliance,* October 2, 1947.

Mothers and Babies Just Stand up and Cheer About

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Seriously . . . it's easy to understand the approval which has greeted the arrival of Baby Quaker. Here are all the body-building, whole-grain qualities of genuine Quaker Oats (Quaker Oats and Mother's Oats are the same), fortified with extra vitamins and minerals, and especially processed for infant digestion. Babies take to its strained smoothness . . . and mothers appreciate the precooking, which means they need add only warm milk or formula. Full technical information furnished upon request.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Foods and Nutrition

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Fat	7.2%	Calcium	230 mg.
Carbohydrate	64.1%	Phosphorus	277 mg.
Fiber	1.7%	Iron	6.6 mg.
Total Minerals (Ash)	4.6%	Thiamine	0.44 mg.
	Per Ounce	Riboflavin	0.063 mg.
Calories	108	Niacin	0.406 mg.

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BABY QUAKER INSTANT STRAINED OATMEAL

Michigan's Department of Health

J. K. Altland, M.D., Commissioner

STUDY IN LABORATORIES

Dr. Jorge Roberto Arevalo of El Salvador, and Jose B. Escobar and Miss Matilde Kruger of Bolivia arrived at the Michigan Department of Health October 1 to spend three or four months studying diagnostic bacteriology in the clinical pathology division of the Laboratories. Their study is under the auspicies of the Institute of Inter-American Affairs.

ADD V D INVESTIGATORS

To work primarily in those counties which have no health departments, two new venereal disease investigators have been added to the staff of the Bureau of Venereal Disease Control. They are Rex DeGrush of Tulsa, Oklahoma, and Richard P. McAvoy of Lansing.

NEED MORE BLOOD

Michigan people must give five times as much blood as they are giving at the present time if blood plasma and fractions are to be available to all who need them after current Red Cross wartime surpluses are exhausted, according to Dr. A. B. Mitchell, Medical Director, Blood Plasma Program, Bureau of Laboratories.

He pointed out three notable changes in the program during its fourth year—the beginning of production of blood fractions, the preparation of emergency donor lists, and the addition of a full time American Red Cross executive for the program.

The Department expects to begin distributing blood fractions—gamma globulin and serum albumin—before the year is out.

PREVIEW OF GERIATRICS

Births during the first half of this year exceeded by nearly 50,000 the deaths during the same period. They exceeded those of any other first half year in the state's history and were exceeded only by those during the last half of 1946. Death figures were higher than last year and marriage figures, lower.

The vital statistics for the first half year follow: births, 78,884; deaths, 29,087; and marriages, 34,227. For the first half of 1946 they were: births, 55,375; deaths, 28,112 and marriages, 36,264.

"One Well!"

Thirteen cases of typhoid in Saginaw County during September were traced to a single private shallow well, twelve feet from the overflow of a newly installed septic tank used by a family which included an unrecognized carrier. This family owned the well, but quit using it in July when city water and the septic tank were installed. Neighbors drank from the well and became ill.

The state now has 265 known typhoid carriers under close supervision. During the past fifteen years typhoid deaths have been cut from 424 to 6. No case of typhoid traceable to a public water supply has been found in thirteen years.

For Better Hearing

To aid in conserving the hearing of Michigan's school children and to help those handicapped by poor hearing, the Department is again providing the services of two hearing consultants to schools. More than thirty-eight counties have requested the service this year.

Buy Hospital X-Ray Equipment

Taking the lead among the states in encouraging general hospitals to make routine chest x-rays of all their patients, Michigan now has twenty-two general hospitals which will x-ray all their 120,000 annual admissions through the use of equipment bought with federal funds and made available to the hospitals by the Bureau of Tuberculosis Control, Michigan Department of Health.

Equipment bought for the hospitals, four of which came into the program during the past year, cost $107,402.97. Some hospitals were given complete equipment and others items to supplement what they already had.

The Bureau of Tuberculosis Control decided to spend part of its federal grant in aid for tuberculosis control in providing equipment for general hospitals because there are more cases of tuberculosis found per one thousand persons examined among admissions to general hospitals than among any other group.

The participating hospitals are in fourteen major cities in the state. They have a bed capacity of 3,942 and total annual admissions of 120,080. These hospitals will x-ray each person admitted, not as a diagnostic study but to find those who have abnormal lung conditions.

The participating hospitals are: St. Joseph Mercy, Ann Arbor; Community and Leila Post, Battle Creek; Community, Coldwater; Receiving, Detroit; Blodgett, Butterworth and St. Mary's, Grand Rapids; Grandview General, Ironwood; Mercy, Jackson; Borgess and Bronson, Kalamazoo; Sparrow and St. Lawrence, Lansing; St. Luke's and St. Mary's, Marquette; Pontiac General, Pontiac; General, Port Huron; Saginaw General and St. Luke's, Saginaw; Munson, Traverse City; and Beyer, Ypsilanti.

Incidence of Communicable Disease

Disease	*September, 1947*	*September, 1946*
Diphtheria	12	16
Gonorrhea	935	1063
Lobar pneumonia	31	35
Measles	161	70
Meningococcic meningitis	13	9
Pertussis	1034	859
Poliomyelitis	276	281
Scarlet fever	88	169
Syphillis	1175	1660
Tuberculosis	622	519
Typhoid fever	20	8
Undulant fever	28	11
Smallpox	0	0

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Acetone Test (DENCO)
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2. A LITTLE URINE

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What's What

The 1948 meeting of the American Medical Association will be held the week of June 21 in Chicago, Illinois.

* * *

The American College of Allergists will conduct a graduate instructional course in allergy at Cincinnati, Ohio, November 3-8, 1947.

* * *

George L. Waldbott, M.D., Detroit, is the author of an original article "The Antihistaminic Drug" which appeared in *JAMA* of September 27.

* * *

The 1947 MSMS House of Delegates created two new Sections: (a) Section on Public Health and Preventive Medicine; and (b) Section on Nervous and Mental Diseases.

* * *

C. P. Mehas, M.D., and Wayne E. Truax, M.D., Pontiac, are co-authors of an original article "Streptomycin in Tuberculosis Meningitis" which appeared in *JAMA* of September 20.

* * *

Winfield B. Harm, M.D., of Detroit, has been appointed as one of the seven members of the Committee on General Practice, authorized by the AMA House of Delegates.

The examinations of the Michigan State Board of Registration in Medicine were held in Lansing, Michigan, on Wednesday, Thursday, and Friday, November 19, 20, and 21, 1947.

* * *

C. E. Umphrey, M.D., Detroit, was elected to the Board of Trustees of the National Physicians Committee for the Extension of Medical Service at its meeting of September 28 in Chicago.

Congratulations, Dr. Umphrey!

* * *

Roger V. Walker, M.D., Detroit, was appointed by the MSMS Executive Committee of The Council to be the representative of the Michigan State Medical Society at the State Rehabilitation Conference in Detroit, September 17-18, 1947.

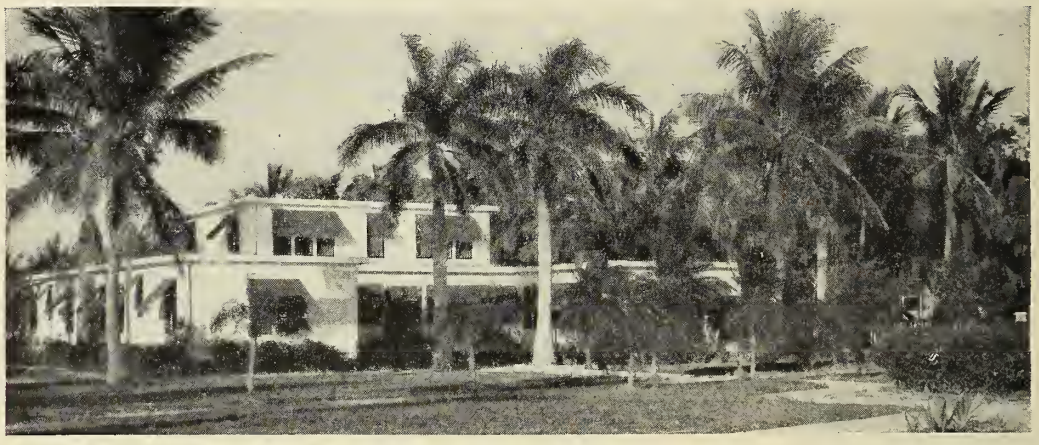
* * *

Max Peet, M.D., of Ann Arbor, Michigan, has been appointed by the Board of Trustees of the AMA to the Advisory Committee on Scientific Exhibits.

* * *

Only fifteen old-age assistance recipients were added last month compared with a normal 390. The secret is

(Continued on Page 1332)



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(Continued from Page 1330)

a new law which permits the state to recover the money from recipients' estates if enough is available. Apparently, relatives prefer to support their aged kinfolk in order to keep their estates intact.—*Michigan Survey,* October 13, 1947.

* * *

Session for General Practitioners.—The October 11 issue of *The Journal of the American Medical Association* outlined the chief subjects to be featured at the general scientific session for the general practitioner which will be held in Cleveland in connection with the midwinter meeting of the American Medical Association House of Delegates, January 5, 6, 7, and 8, 1948.

* * *

The Michigan Allergy Society will meet in the Michigan Room, Statler Hotel, Detroit, December 18, at 6:00 p.m. Albert H. Rowe, M.D., San Francisco, author of "Food Allergy," will speak on "Clinical Aspects of Food Allergy With the Use of the Elimination Diet." For reservations contact M. M. Fenton, M.D., 1212 Broderick Tower, Detroit 26, telephone Cherry 1504.

* * *

The National Gastroenterological Association announces its annual cash prize award contest for the best unpublished contribution on gastroenterology or allied subjects. Entries for the prize shall be received by April 1, 1948. For full information write the Association at 1819 Broadway, New York 23, New York.

* * *

Wm. A. Hyland, M.D., Grand Rapids, has been appointed as the MSMS representative on the State Advisory Committee for the Practical Nurse Training Program, a part of the State Board of Control for Vocational Education, under Eugene B. Elliott, Superintendent of Public Instruction.

* * *

Thomas Francis, Jr., M.D., Ann Arbor, was recipient of one of the five 1947 Lasker Awards at the 1947 session of the American Public Health Association in Atlantic City on October 9. Dr. Francis was honored for his contribution to knowledge of influenza and aid in development of a successful vaccine.

Congratulations, Dr. Francis!

* * *

James A. Paullin, M.D., Atlanta, Professor of Clinical Medicine of Emory University, and former President of the American Medical Association and of the American College of Physicians, has been appointed a member of the Federal Hospital Council, established last year to assist Surgeon General Thomas Parran of the USPHS in the administration of the hospital survey and construction program.

* * *

The third annual Cancer Day, sponsored by the Calhoun County Medical Society and the Calhoun County Cancer Society, was held in Battle Creek on November 4, 1947. Speakers were Hugh J. Jewett, M.D., Baltimore, Md., and Jas. H. Maxwell, M.D., Ann Arbor. These guests, together with Stanley T. Lowe, M.D.,

Say you saw it in the Journal of the Michigan State Medical Society

Battle Creek, entered into a panel discussion as a public information radio broadcast over Station WELL on the evening of the Cancer Day. One hundred thirty-eight physicians were registered at the meeting.

* * *

Taft Health Bill.—At the Atlantic City meeting of the American Medical Association, the Reference Committee on Reports of Board of Trustees and Secretary had this to say about S.545:

> "S.545, the so-called Taft Bill, as now written, approximates a legislative background for the development of a health program for the American people as set forth in the broad national health program of the American Medical Association."

* * *

Have you had an Organization Seminar in your county? At these meetings in the individual counties, arranged by the Michigan State Medical Society upon invitation of the county, local problems are discussed and the intimate details of the MSMS work and program are brought to the county society officers and members through a round-table discussion and through three short (10-minute) talks.

If you desire an Organization Seminar in your county contact your Councilor.

* * *

Coming MSMS Meetings:

1. County Secretaries and Public Relations Conference, Book-Cadillac Hotel, Detroit, Sunday, January 25, 1948.
2. Second annual Michigan Postgraduate Clinical Institute, Book-Cadillac Hotel, Detroit, Wednesday, Thursday, Friday, March 10, 11, 12, 1948.
3. MSMS Annual Session, Book-Cadillac Hotel, Detroit, Wednesday, Thursday, Friday, September 22, 23, 24, 1948.

* * *

The Library of Finland's Technical Institute, Teknillinen Korkeakoulu, during the war was bombed and totally destroyed. Scientific and technical books and periodicals from America will be welcomed to take the place of those destroyed. This would be a practical act of friendship to a nation that holds America in high regard. Gifts should be marked for the Institute of Technology, Helsinki, in care of the Legation of Finland, 2144 Wyoming Avenue N.W., Washingtion, D. C., attention of Dr. K. T. Jutila, the Finnish Minister.

* * *

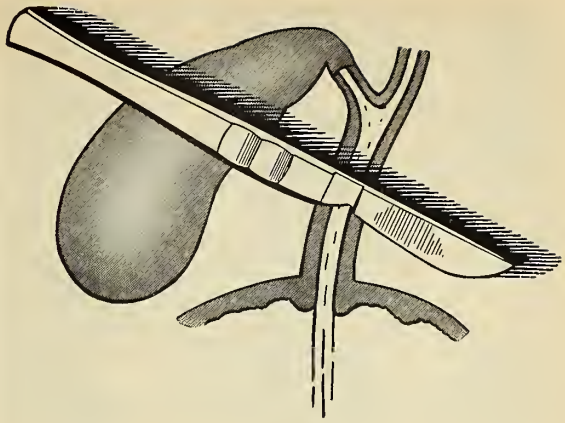
Hugh W. Brenneman, Lansing, MSMS Public Relations Counsel, addressed Kiwanis Club at Williamston on Monday, September 15, on "Rural Health in Michigan."

Mr. Brenneman was interviewed by Forest A. Smith over WKAR on the Grange hour on the subject of the Michigan Rural Health Conference, Saturday, September 13 at 10:30 a.m.

Mr. Brenneman also spoke over WKAR on Monday, October 6, 1947, at 4:00 p.m. on the subject "A Good Program of Health for Rural Michigan" on the Michigan Education Association broadcast.

* * *

The Council of the Michigan State Medical Society, at its meeting of September 21, 1947, in Grand Rapids,



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*Goldthwait, J. E., Brown, L. Y., Swaim, L. T., and Kuhns, J. G., *Body Mechanics in Health and Disease,* 103-105, J. B. Lippincott Co., Philadelphia, 1937.

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discussed the gradual infiltration of an ideology to coordinate various state health agencies having to do with curative medicine into one agency under the direction of the State Health Department whose function is that of preventive medicine. The Council strongly recommended the maintenance of the present independence of agencies such as the Michigan Crippled Children Commission, which are concerned with curative medicine.

* * *

Three Grand Rapids physicians recently were chosen for award of Edward and Susan Lowe fellowships for special postgraduate study in their profession. Gerritt E. Winter, M.D., Kent A. Dewey, M.D., and E. Hemingway Fuller, M.D., each will receive an award of $500, to be used for postgraduate clinical or similar instruction and experience outside Grand Rapids, "with a view to increasing ability to render professional medical or surgical service of the highest order." Drs. Dewey and Fuller will take postgraduate work in surgery; Dr. Winter in obstetrics.

* * *

Progress of Prepayment Plans.—The Council on Medical Service of the AMA reports that midyear enrollment in voluntary prepayment medical care plans is safely past the six million mark. Countrywide, this represents enrollment growth at the rate of approximately 200,000 new subscribers per month. The range of percentage increases for the six-month period was from 4.9 to 763.2 with an over-all average of 31 per cent.

Eighteen of the voluntary prepayment medical care plans reported a June 30 enrollment of more than 100,000 each. Four of them reported enrollment in excess of 500,000.

* * *

Talk With Your Representatives.—During the Christmas recess most members of Congress will be at home. Don't overlook the opportunity of talking with your representative on pending health legislation. For example, there are two bills—S. 1714 to provide for maternal and child health and S. 1734 to provide for national unemployment and temporary disability insurance—which are worth more than passing attention. (See page 1551, August 30, 1947, issue of *J.A.M.A.*)

If you read the preambles of these two bills, you will notice that they represent more social legislation along the same line as the Wagner-Murray-Dingell bills. A digest of the bills would lead one to believe that "the American people are really in a poor way."

* * *

The AMA Committee on Awards honored two groups of Michigan physicians for their scientific exhibits displayed at the centennial meeting in Atlantic City last June. Certificates of Merit in Group I were awarded to:

1. Hugh A. Freund, Gabriel Steiner and Carl E. Duffy, Harper Hospital and Wayne University College of Medicine, Detroit, for the exhibit on "Recent Advances in Studies of Rheumatoid Arthritis."

2. E. S. Gurdjian, J. E. Webster and H. R. Lissner, Wayne University College of Medicine and Grace Hos-

(Continued on Page 1336)

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(Continued from Page 1334)

pital, Detroit, for the exhibit on "Mechanism of Production of Linear Skull Fracture—Studies with the Stresscoat."

Congratulations!

* * *

Frank E. Reeder, M.D., Flint, long-time Delegate in the MSMS House of Delegates as well as delegate from MSMS to the AMA House of Delegates, was honored by the Genesee County Medical Society on October 22 for his long service to his County and State societies.

One hundred seventy-two physicians in Genesee and neighboring counties, including officers of the Michigan State Medical Society, were present at the testimonial dinner honoring "Tony" Reeder, a physician who is a friend of all who ever came in contact with him.

* * *

Sickness statements for rail workers.—Physicians are being asked to furnish medical evidence to substantiate the claims of railroad workers who may now draw cash sickness benefits under the Railroad Unemployment Insurance Act. The Railroad Retirement Board points out that unless an application is mailed not later than the seventh day after the first day of sickness claimed, it may not be received within the legal time limit for filing applications. As a result, the employe may lose one or more days' benefits. Doctors are asked either to return each completed Statement of Sickness to the patient, or mail it promptly to the office of the Board to which it is addressed.

* * *

First Michigan Rural Health Conference.—This very successful experiment in public relations with Michigan's rural groups, held on the campus of Michigan State College, East Lansing, September 18-19, 1947, brought out three important recommendations:

1. Authority to set up a committee to arrange for a second Michigan Rural Health Conference in 1948, and to assume responsibility implementing the resolutions already passed by this Conference.
2. Authority to set up a committee to investigate a students' medical scholarship fund.
3. Authority to set up a committee to plan and assist in the organization of local health councils in rural areas, with the approval of the county medical society.

* * *

The American Academy of General Practice of Wayne County sponsored a two-day course of Postgraduate Lectures for general practitioners at Henry Ford Hospital, Detroit, on November 19-20. Speakers at the first annual lecture course were Drs. James I. Baltz, Frank R. Menagh, Dwight C. Ensign, J. P. Pratt, Wm. E. Jahs-

(Continued on Page 1338)

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(Continued from Page 1336)

man, W. R. Chambers, Lawrence S. Fallis, John W. Keyes, J. Lewis Dill, Donald W. Hedrick, Arthur B. McGraw, Don H. Bellinger, Robt. H. Durham, Wm. L. Lowrie, Conrad R. Lam, Benjamin E. Goodrich, J. A. Johnston, Hawley S. Sanford, Ormand S. Culp, C. Leslie Mitchell, Brock E. Brush, James O. Olson, Joseph Shaffer, Howard P. Doub, Donald S. Bolstad, C. P. Hodgkinson, F. Janney Smith, Frank W. Hartman, John K. Ormand, Robert F. Ziegler, Frank J. Sladek, Clark M. McColl, Lewis J. Steiner, John G. Mateer, E. J. Alexander, Philip J. Howard, H. L. Stewart, Jr., and W. E. Redfern, all of Detroit.

Roy D. McClure, M.D., was the main speaker at the Banquet held in the Hotel Fort Shelby on Thursday evening, November 20.

* * *

Sulfonamides for Local Application Deleted from N.N.R.—Nearly two years ago the Council on Pharmacy and Chemistry published a report on the "Dangers from External Use of Sulfonamides," citing the evidence then available that the promiscuous use of these drugs in the form of ointments, lotions, powders and other preparations suitable for local application resulted in the sensitization to these drugs of a high proportion of those treated. Since that time, evidence has continued to accumulate confirming the views then expressed that the local application of these drugs should be limited to the

(Continued on Page 1340)

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(Continued from Page 1338)

relatively few cutaneous infections known to respond to this form of therapy and that such medication should be administered only under the careful supervision of a physician. Recently Lyons has emphasized the reasons for abandoning the local use of the sulfonamides in treating wound infections, citing the experience gained in World War II which showed that these drugs delayed healing and were otherwise definitely deleterious, and furthermore that these drugs were ineffective for the purpose for which they were used, namely, wound sterilization.—*J.A.M.A.*, Sept. 20, 1947.

* * *

Veterans Administration.—Effective October 15, 1947, applications for medical treatment of veterans who have not previously filed claims and who have been discharged from service for one year or more, will not be granted *prima facie* evidence of service connection. Adjudicative action must be taken before authorized medical treatment by the Veterans Administration is permitted in these cases. The basic right of the veteran to apply for treatment and pension for service-incurred disabilities has not been disturbed.

VA estimates that at least sixteen million veterans will come out of World War II. This includes all veterans discharged by the armed forces through June 30 plus all soldiers, sailors, marines and others still in service on the same date. The potential veteran poulation will in-

(Continued on Page 1342)

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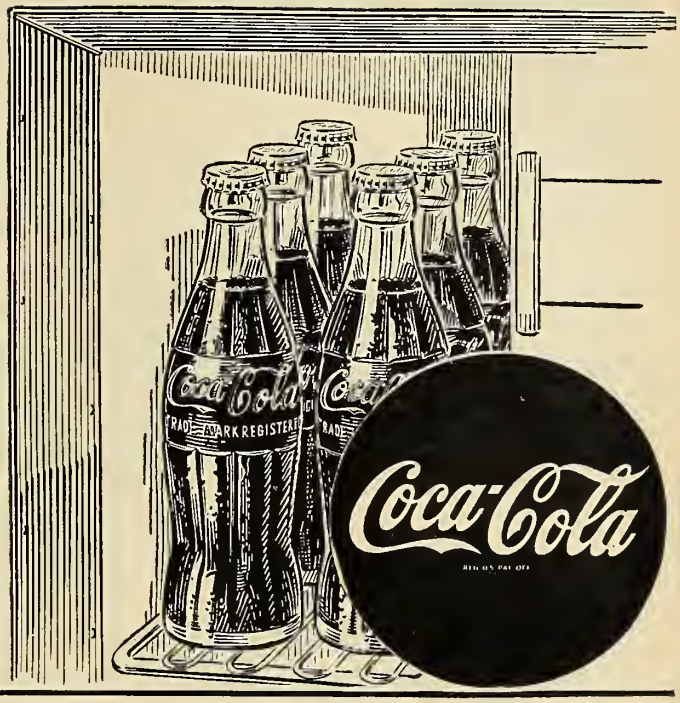

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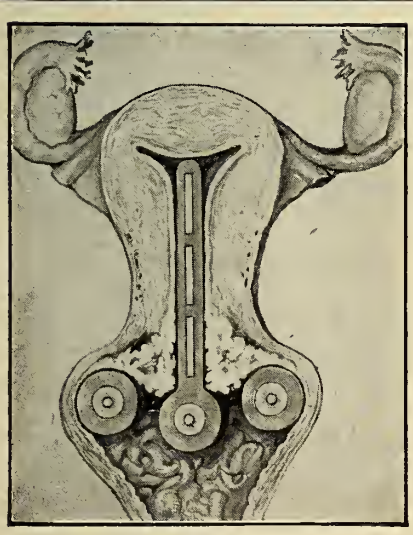

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(Continued from Page 1340)

crease until the official termination of the war which as yet has not been declared. By comparison, World War I produced 4,627,000 veterans, the Civil War, 1,849,000 union army veterans, and the Spanish American War, 381,000 veterans, making a combined total of 6,857,000 for the three wars, or considerably less than one-half of the minimum estimated for World War II alone.

VA states that after a converted National Service Life Insurance policy has been in effect for one year, the insured veteran may apply for a loan or for the cash surrender.

* * *

Alex W. Spain, M.D. of Dublin, Ireland, was guest speaker at the opening autumn meeting of the West Side Medical Society on October 8. The meeting, the first to be held in the Community War Memorial Building on Greenfield Rd., Detroit, was presided over by L. J. Gariepy, M.D., President of the West Side Society, a branch of the Wayne County Medical Society. Dr. Spain paid tribute to the Sisters of Mercy whose original home and hospital are in Dublin. He also praised President Gariepy for his organizational work in connection with Detroit's Mt. Carmel Mercy Hospital and for the large attendance at the West Side Medical Society meeting which Dr. Spain addressed.

Besides discussing "Obstetrics and Gynecology in Ireland," he also outlined economic and political conditions

(Continued on Page 1344)

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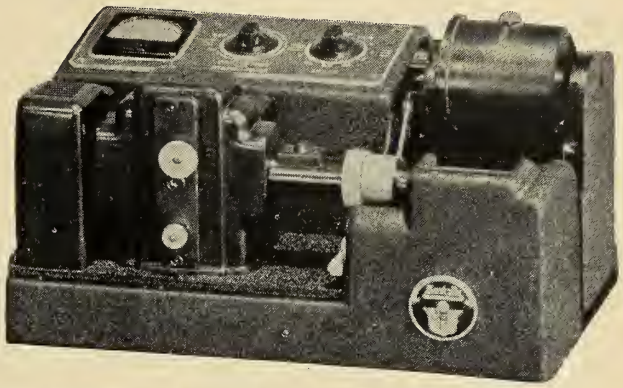

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Acknowledgment of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

COMMUNAL SICK-CARE IN THE GERMAN GHETTO. By Jacob R. Marcus, Ph.D., Adolph S. Ochs Professor of Jewish History, Hebrew Union College, Cincinnati. The Hebrew Union College Press, 1947. Price $2.50.

The history of the Jewish people and their care during the past several centuries is that of communal care. Most of this care was rendered by Jewish physicians, but not all. The author tells of the appeal to the city authorities of Frankfort in 1631 for permission to appoint a Jewish physician to care for the community. The Jewish physician did not make a living from the modest salary paid him for his communal services, and had to take other patients. In 1698 a Holy Brotherhood of Circumcisors was established—new recruits must intern a year, one who had done three bad cases must not do any more, and if a man was too dependent on his spectacles he must not act as a circumcisor. Communal care continued until late in the eighteenth century when the Hebra Kaddisha became established. This was probably a sick-care society, and is claimed to have existed in Palestine, but there is evidence of establishment of them in Spain about 1265. They appeared in Prague about 1564. There was much discussion of them up to about 1880. Jewish hospitals came into existence in the early 1800's.

There is an abundance of letters, records, both in English and Hebrew. The book is an interesting study of the development of care of the Jewish people, and the improvement and acceptance of Jewish doctors.

MAY'S MANUAL OF THE DISEASES OF THE EYE. For Students and General Practitioners. Nineteenth Edition, Revised and Edited by Charles A. Perera, M.D., Assistant Clinical Professor, College of Physicians and Surgeons, Columbia University, New York; Assistant Attending Ophthalmologist, Presbyterian Hospital, New York. With 387 illustrations, 32 plates and 93 colored figures. Baltimore: Williams and Wilkins Company, 1947. Price $4.00.

Dr. May's manual of diseases of the eye has been a favorite since the first edition in 1900. The book has increased in size, the text is still the delightful style it has always been, and the illustrations have been multiplied and are of sufficient detail and clearness to be a very valuable help in understanding. Old illustrations have been replaced by new and more up-to-date ones. Modern methods, the newest drugs and remedies like penicillin, new theories of color, have been added. This edition will receive just as sure a welcome as have the past ones. The present editor assisted Dr. May in the last four editions, so is not new to the task.

INTERNAL MEDICINE IN GENERAL PRACTICE. By Robert Pratt McCombs, B.S., M.D., F.A.C.P., Assistant Professor of Medicine and Director of Postgraduate Teaching, Tufts College Medical School; Senior Attending Physician, The Joseph H. Pratt Diagnostic Hospital; Diplomate of the American Board of Internal Medicine. Second Edition. 741 pages with 122 illustrations. Philadelphia and London: W. B. Saunders Co., 1947. Price $8.00.

Methods of diagnosis receive an introductory chapter, caution being given for accuracy of findings. Diseases are

(Continued on Page 1348)

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(Continued from Page 1346)

then considered, beginning with psychiatric disorders, which merit considerable study. Heart disorders, hypertension and urinary tract, with colored pictures of the fundus oculi are next. Each disease is carefully differentiated from others with similarities. Treatment is definite with reason and method. All systems of the body are studied.

This book is not voluminous, but is complete. It should be welcomed by the new specialty, General Practice.

ANNUAL REPRINT of Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1946. Cloth. Price, postpaid, $1.00. Pages 135. Chicago: American Medical Association, 1947.

This volume was formerly of most interest to those who wished to know why the Council on Pharmacy and Chemistry had not accepted certain of the preparations it had considered. The reports were mainly those of rejection; though, through the years, the educational nature of the Council's work was attested by status reports on drugs, or therapeutic procedures, or preliminary reports on agents showing promise of usefulness but not yet ready for adoption by the general and medical profession. In recent years, the tendency has been toward a preponderance of the educational type of report. In the present volume, both the condemnatory and the educational phases of the Council's work are represented.

There are three reports of vigorous condemnation: first, the report on Cabasil, a curiously unscientific mix-

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ture whose exploitation for use in a multitude of diseases is aptly summarized by the subtitle of the report, "Quackery Unlimited"; second, the report on the pseudoscientific Ethylene Disulphonate (Allergosil brand), a preparation of highly uncertain nature exploited to physicians for use in allergic conditions; third, Formula A-N-1, a joint report of the Council on Pharmacy and Chemistry and the Council on Industrial Health, concerning an expensive but poor substitute for aspirin and citrate of magnesia, cleverly promoted to industrial concerns for use in reducing absenteeism due to colds.

Among the status reports, the excellent article of Dr. Samuel M. Feinberg, "Histamine and Antihistaminic Agents," is probably most worthy of mention. Since its appearance, the Council has accepted for inclusion in *New and Nonofficial Remedies,* the two new agents of this class evaluated in the article, Diphenhydramine Hydrochloride, and Tripelennamine Hydrochloride (Benadryl Hydrochloride and Pyribenzamine Hydrochloride, respectively).

Pharmaceutical and scientific investigators, alike, will be interested in the informative report on the Council's new Therapeutic Trials Committee. Of special interest to manufacturers is a statement on the revised rules of the Council, though this exposition of the trends of Council policy is of concern to all who are interested in progressive rational therapeutics.

Attention is called to the several reports on the adoption of generic designations for drugs proposed or marketed under protected names. Not all such actions of the Council have been the subject of separate published reports; the recognized terms have appeared in the published descriptions of the drugs when accepted, and will be inserted in another Council publication, *New and Nonofficial Remedies,* as adoption of such designations for already accepted protected names proceeds.

THE AMERICAN ILLUSTRATED MEDICAL DICTIONARY. A complete dictionary of the terms used in Medicine, Surgery, Dentistry, Pharmacy, Chemistry, Nursing, Veterinary Science, Biology, Medical Biography, etc., with Pronunciation, Derivation and Definition. By W. A. Newman Dorland, A.M., M.D., F.A.C.S., Lieut. Col., M.R.C., U. S. Army; Member Committee on Nomenclature and Classification of Diseases of the AMA; Editor of "American Pocket Medical Dictionary." Twenty-first Edition. 1660 pages; with 880 illustrations, including 233 portraits. With the Collaboration of E. C. L. Miller, M.D., Medical College of Virginia. Philadelphia and London: W. B. Saunders Company, 1947. Price $8.00 without Thumb Index; $8.50 with the Thumb Index.

Another edition of Dorland's dictionary is available, and has the words invented yesterday. The growth of medical vocabulary is rapid due to new research and discoveries, and a book to keep up with that development must be frequently revised. This book has been thoroughly scrutinized throughout. It is a beautiful

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sample of the bookmaker's art, with flexible covers, good paper, and type. The words are blackface to facilitate reference. A must in any medical library, or the doctor's desk without a library.

ADVANCES IN INTERNAL MEDICINE, Volume 2. Editors: William Dock, M.D., Long Island College of Medicine, Brooklyn, N. Y.; I. Snapper, M.D., The Mount Sinai Hospital, New York, N. Y. Associate Editors: Tinsley R. Harrison, M.D., Southwestern Medical College, Dallas, Texas; Chester S. Keefer, M.D., Evans Memorial and Massachusetts Memorial Hospitals, Boston, Mass.; Warfield T. Longcope, M.D., Cornhill Farm, Lee, Mass.; George R. Minot, M.D., Thorndike Memorial Laboratory, Boston City Hospital, Boston, Mass.; J. Murray Steele, M.D., Goldwater Memorial Hospital, New York University Division, Welfare Island, N. Y. New York: Interscience Publishers, Inc., 1947. Price $6.75.

Internal medicine advances so rapidly that careful selection is necessary of the items to be discussed in this book. Each chapter is assigned to a different author, and they make a complete review entity. The articles on "Ventricular Complex of the Electrocardiogram," and the "Problem of the Rhesus Antigen" are especially worthy of study. The article on pernicious and other anemias is an eye opener to younger men not familiar with the problem of a generation ago. This book is a valued agenda for the internist and also the progressive general practitioner.

ADVANCES IN PEDIATRICS. Editorial Board: S. Z. Levine, Cornell University Medical College, New York; Allan M. Butler, Harvard Medical School, Boston; L. Emmett Holt, Jr., New York University, College of Medicine, New York. Volume II. New York: Interscience Publishers, Inc., 1947. Price $9.50.

The authors have made a complete study of the year's progress in pediatrics, and this second year have published a readable book dealing mostly with new subjects, new techniques, and have assigned various subjects to a list of sixteen well known authorities. The result is a symposium type work that is a complete exposition of the material and makes a handy and permanent refresher course.

Physicians can be divided into two great groups, those who are learning and those who are forgetting, those who each year know more and those who each year know less. There seems no third group, those who are stationary.

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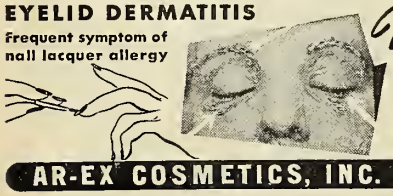
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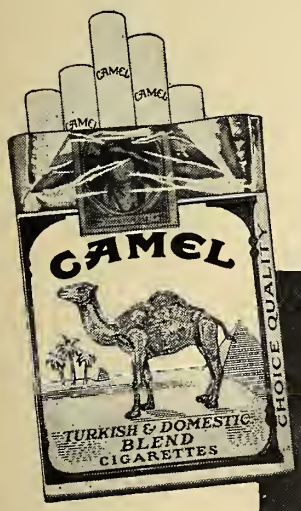

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(Continued on Page 1360)

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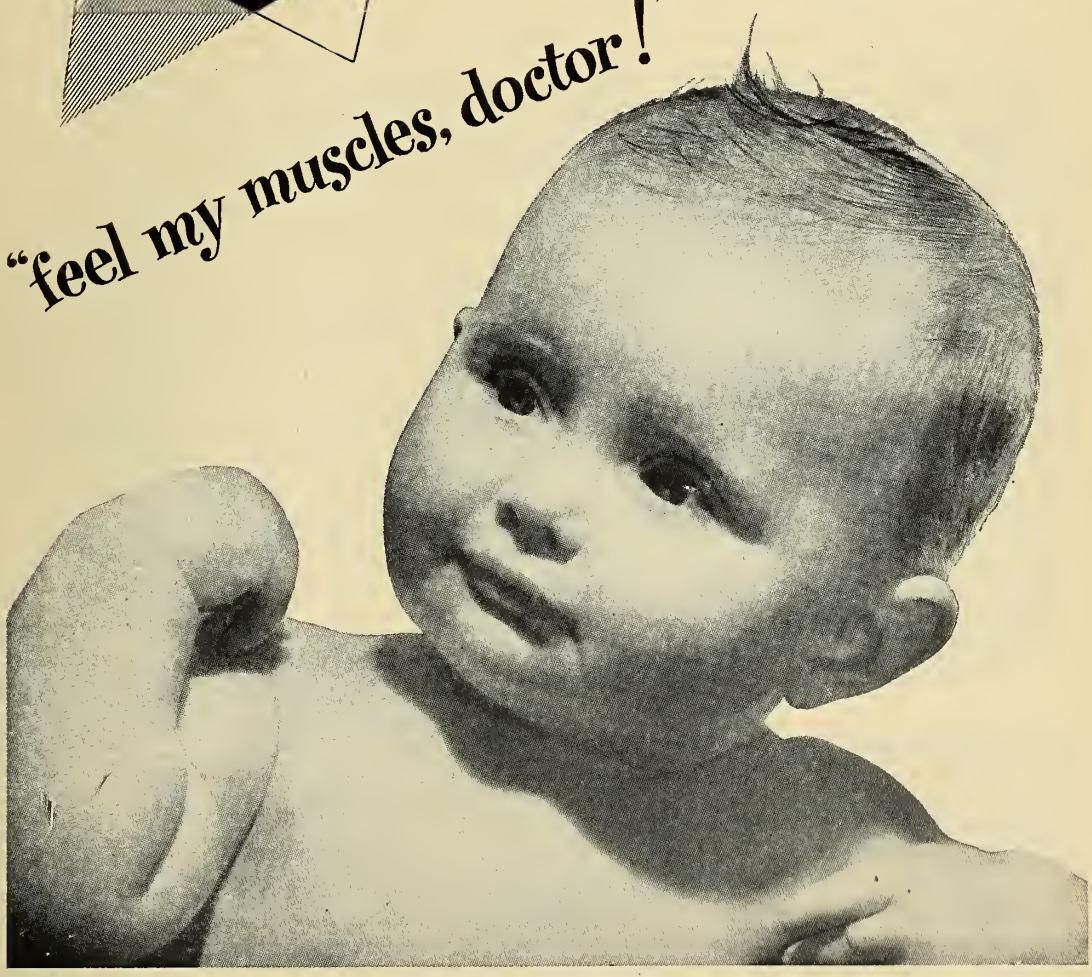

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(Continued from Page 1360)

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(Consultant) ..... Manistique

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* * *

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*Goodman, L., and Gilman, A.: The Pharmacological Basis of Therapeutics, New York, The Macmillan Company, 1941, p. 433.

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Plan of Community Leadership in Health

In the words of William A. Hyland, M.D., in his presidential address delivered in Grand Rapids at the 82nd Annual Session; "The Michigan State Medical Society is on the offensive and is going to stay on the offensive." Dr. Hyland was referring to the many activities of the Society that are making rapid strides towards the meeting of existing health needs through organized effort on the part of the Doctors of Medicine in Michigan. Current activities indicate that the majority of these projects are past the planning stage and in active operation. In their aggregate, they constitute a Plan for Community Leadership in health as they develop on the local level. In direct proportion to the growth and success of this community plan, the public relations of organized medicine develops and becomes more effective, for in essence, the Michigan State Medical Society public relations program consists of finding the needs, setting up a program to meet those needs, creating the projects to carry out the program, and then telling the people what is being accomplished.

The Community Leadership Plan involves a great many activities and groups:

• It calls for a detailed survey of existing health needs on the community level. This is being done through the Social Research Service of Michigan State College, under the direction of the Health Survey Advisory Committee of the MSMS, with funds provided by this Society and the Michigan Foundation for Medical and Health Education, Inc.

• It makes necessary the calling together of groups who are interested in health activities such as was done at the Michigan Rural Health Conference held last September in East Lansing.

• It encourages and stimulates the development of disease control programs such as the Rheumatic Fever Control Program, the Cancer Control Program, the Venereal Disease Control Program, et cetera.

• It includes and supports the Community Enrollment Plan of Michigan Medical Service—Michigan Hospital Service.

• It involves the education of practitioners of medicine for rural areas through the development of scholarships and loan funds for students who desire to practice in small localities. Such funds are being investigated, and a plan for their procurement evolved by the Michigan State Medical Society Rural Medical Service Committee.

• It requires action on the part of county medical societies to correct any impractices which may exist in their communities, such as those cited at the 1947 meeting of the House of Delegates.

• It asks for the setting up of Community Health Councils to formulate and carry out action for worth-while projects in the various towns and cities.

• It makes possible an enlightened use of funds for hospital construction made available under the Michigan Hospital Survey and Construction Act.

• Perhaps most important, it requires that every doctor of medicine be informed and kept informed on the activities of his Society so that he can properly interpret them to his patients and friends. A start in this direction is being accomplished by the publishing of the "Medical Plan for Michigan" which is a factual compendium of the many activities and projects of organized medicine in Michigan.

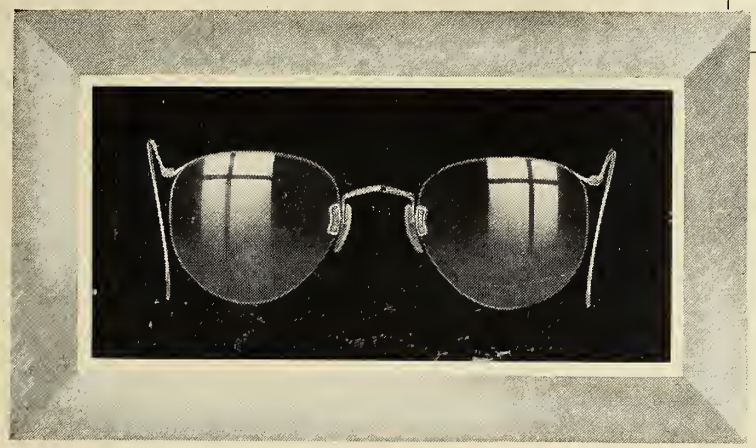
You will hear more of the plan for Community Leadership. In the meantime, your activity in diagnosing the medical and health socio-economic ills of your community can be of valuable service to your officers and representatives. Your constructive comments and criticisms are invited.

"TELL ME, DOCTOR"

Two more radio stations have been added to the transcribed network carrying the "Tell Me, Doctor" radio program sponsored by the Michigan State Medical Society. Radio Station WHFB in Benton Harbor started the program on a daily basis Monday through Saturday on November 22. The presentation is made under the auspices of the Mercy Hospital.

Radio Station WMRP in Flint, Michigan, started the program on a five-day a week basis beginning December 15. The program is being run on a sustaining basis, and it is expected that soon it will be sponsored by a local business firm.

The addition of these two stations brings to seventeen the total of stations broadcasting "Tell Me, Doctor."



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DOCTOR! THAT PRACTICE OF YOURS GROWS,

becomes sound, solid, impregnable, growing always . . . when it is founded on the *complete satisfaction* of your patients.

PATIENTS come to you in thick streams because of your *reputation*, because they *believe* in you, because they *like* you.

They come because they've a kind of unquestioning confidence in your medical skill that is priceless.

Their confidence deepens, and it spreads, as the years roll on, when each individual and entire neighborhood opinions voice approval and stout confidence in your skills and in all that *you* say and do.

You gave them better *vision;* you provided *smarter* modern mountings appropriate for *their* wear; you provided them with *comfort* in the wearing of . . . glasses. That is basis for their unquestioning confidence.

May *we* help you to build such reputation; may we help you to hold it all your lifetime? Will you *lean* on us?

We'll fill the prescriptions that you give your patients with an ability and an integrity that will adhere to *your* standards, to Uhlemann Physician's Quality Standards.

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. . . . . that the glasses that give them *better* vision be smart in appearance and comfortable to wear . . . that *your* patients may be always *completely* satisfied.

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ESTABLISHED 1907

Conference of State Medical Association Secretaries and Editors

A conference of the editors and secretaries, including the executive secretaries, of the various state medical societies is held every year at the headquarters of the American Medical Association. This group first was convened in Saint Louis, Missouri, in 1910, at the annual meeting of the AMA. At the session held November 7 and 8, 1947, there were just two members present who were at the first meeting—Holman Taylor, M.D., Texas, and Wilfrid Haughey, M.D., Michigan. Dr. Taylor has attended every intervening meeting.

This year's gathering had many important subjects to study. E. L. Henderson, M.D., chairman of the Board of Trustees of the AMA, opened the meeting with appropriate remarks. The first speaker, Bruno Gebhard, M.D., Director of the Cleveland Health Museum, talked on "Methods and Technics of Preparing Display Exhibits for Lay People." Oscar B. Hunter, M.D., of Washington, D. C., had as his subject for discussion, "Effective Scientific Programs," and he had many suggestions for the building of a suitable and attractive program. G. Halsey Hunt, M.D., of the United States Public Health Service, reported on a "Survey of Group Practice" that had been conducted by the department. He told of experiences in studying over one hundred groups, classified the groups, and spent much of his time outlining the methods of organization, of dividing the income, and suggested that some groups give the patrons the benefit of group consultation, but not all—some, because of the form of their group, are really competitors. Some of us wondered why the USPHS should spend much money and time for this type of survey. Was it for scientific purposes or propaganda?

Charles H. Keene, Editor of the *Journal of School Health*, read an interesting paper on "The Private Physician in the School Health Program." He advocated a much greater participation than now exists. There are many points in the school health program that acutally belong to medical practice but have been taken over by pressure groups or other interested groups, and others are likely to be lost to the profession. Most school authorities would be glad of help from the medical profession.

The first afternoon was partly taken up by a panel discussion on the progress of "Prepayment Medical Care Plans." James R. McVay, M.D., chairman of the Council on Medical Service of the American Medical Association, discussed "Medical Society Plans"; Charles H. Crownhart, secretary of the State Medical Society of Wisconsin, talked about "Co-operatives"; L. Howard Schriver, M.D., president of Associated Medical Care Plans, Inc., told about his organization and its activities; Alfred W. Adson, M.D., member of the Council on Medical Service of the American Medical Association, talked about "Private Insurance Plans." Then followed a general discussion in which it was brought out that the medical profession has accomplished much in its studies and plans, but has failed to sell these plans to every person on the street—we have not gotten the publicity we should.

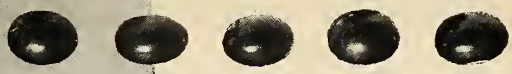
The Conference then broke up into discussion groups: "Public Relations," L. Fernald Foster, M.D., Secretary, Michigan State Medical Society, Moderator; "Relations with Labor," Norman M. Scott, M.D., director of Medical Care Plans, Medical Society of New Jersey, Moderator; "Federal and State Legislation," W. P. Anderson, M.D., secretary, Medical Society of the State of New York, Moderator; "Rural Medicine," R. B. Adams, M.D., secretary, Nebraska State Medical Society, Moderator; "Planning and Conducting State Medical Conventions," John C. Parsons, M.D., secretary, Iowa State Medical Society, Moderator.

Alfred J. Jackson reported on the work of the Co-operative Medical Advertising Bureau, comprising thirty-five state medical journals. The work has been increasingly successful.

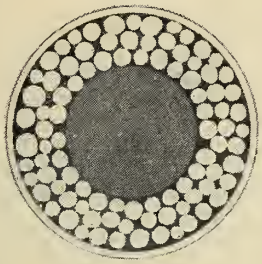
In the evening, the convention divided into two sections. The Editors held a clinic on the state medical journals. Four of the journals were selected and studied in detail by experts who brought their findings to the conference. Robert H. Roy, Chief Engineer, Waverly Press, and Associate Professor of Industrial Engineering, Johns Hopkins University, talked on "Format and Topography." He gave us many pointers on the mechanical make-up of the journals, commending some and criticizing others, giving valid reasons for his remarks. Harry Shaw, General Editor, Harper and Brothers,

(Continued on Page 1372)

THE *Coating* MAKES THE DIFFERENCE



The Barlow-Maney Enteric Coating* employs a rationale adapted from the physiology of digestion. Specially developed, unique, *in vitro* tests demonstrate its effectiveness—clinical radiography confirms it.
The coating of Barlow-Maney Tablets Aminophylline Enteric Coated is described in New and Nonofficial Remedies, 1946.



LABORATORY TEST

Fig. 1 — Tablet in stomach; only the outer sugar coating is affected.

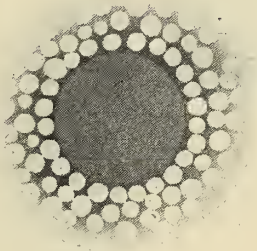


Fig. 2 — Tablet in duodenum. Liver bile plus increased alkalinity hastens emulsification of lipids of coating.

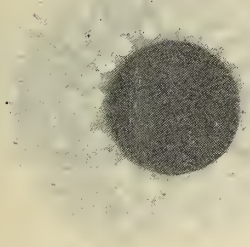
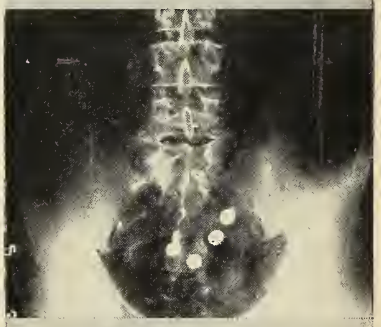


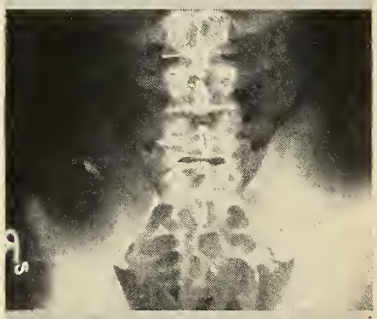
Fig. 3 — Complete disintegration.

CLINICAL CONFIRMATION

Radiograph taken five minutes after intake of 6 tablets Enteric Coated B-M . . . all tablets are in stomach.



Four hours later . . . all tablets now in intestines.



Six hours later . . . all tablets disintegrated or in that process.

We direct your attention to AMINOPHYLLINE ENTERIC COATED B-M — valuable when the patient experiences gastric irritation from aminophylline.

*Coated under license from the State University of Iowa Research Foundation. U. S. Patent 2,373,763.

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MSMS Honors Officials of Michigan Society for Crippled Children

Two Michigan State Medical Society Awards for Health Service were made to Emmet Richards of Alpena, and to P. C. Angove of Detroit, President and Executive Director, respectively, of the Michigan Society for Crippled Children and Disabled Adults, Inc., on the occasion of the Crippled Children Society's annual conference in Bay City on October 31. The Awards were presented to Messrs. Richards and Angove by L. Fernald Foster, M. D., Bay City, Secretary of the Michigan State Medical Society, who cited the health work of the two awardees and their special interest in Michigan's Rheumatic Fever Control Program:

EMMET RICHARDS RECEIVES MSMS AWARD
Emmet Richards, Alpena (*left*), President of the Michigan Society for Crippled Children and Disabled Adults, Inc., being presented with the MSMS Health Service Award by L. Fernald Foster, M.D., Secretary of the Michigan State Medical Society, on the occasion of the 24th Annual Conference of the Michigan Society for Crippled Children in Bay City, October 31, 1947.

"With the enthusiastic co-operation and support of Mr. Richards and Mr. Angove," stated Dr. Foster, "the Michigan State Medical Society was able to inaugurate its well-thought-out program of rheumatic fever control. The tangible assistance of these two health-minded men meant the vast difference between high success or tragic failure for our experiment in rheumatic fever control. These friends of medical progress have proven by their distinguished health service that they are true friends of the people of this State. Literally, they are contributing life and health to the youngsters of our commonwealth—who otherwise might face lingering illness and perhaps death from America's No. 1 child killer."

Health Service Award

The two Health Service Award scrolls, presented to Messrs. Richards and Angove, contain the following phraseology:

"For valued service rendered to the health of the people; for creative thought and constructive effort in the cause of humanity, this Health Service Award is presented by the Michigan State Medical Society."

MSMS HEALTH SERVICE AWARD TO P. C. ANGOVE
P. C. Angove, Detroit (*right*), Executive Director of the Michigan Society for Crippled Children and Disabled Adults, Inc., receiving the MSMS Health Service Award from L. Fernald Foster, M.D., Secretary of the Michigan State Medical Society. Mr. Angove has given extraordinary co-operation and service in health projects, particularly in Michigan's successful Rheumatic Fever Control Program.

New York Times Praises MSMS Rheumatic Fever Control Program

The *New York Times* of Sunday, October 26 contained a feature article by Howard A. Rusk, M.D., entitled "Michigan Program Is Hailed as Curb on Rheumatic Fever." The subtitle of this excellent story, which included ten educational paragraphs on the history and etiology of the disease, praised the Michigan Program thus, "New Long-

(Continued on Page 1372)

A richer life...

...for your petit mal patients

Immediate and substantial improvement in the great majority of cases—that is the encouraging prospect offered by Tridione to thousands of children suffering from *petit mal*. Tridione has achieved an outstanding clinical record in this field. In one study, for example, Tridione was given to 166 patients suffering from *petit mal* (pyknoepilepsy), myoclonic jerks or akinetic seizures.[1] This group had received only mediocre benefits from the use of other medicaments. With Tridione *83% were definitely improved.* Thirty-one percent became free of seizures; 32% had less than one-fourth of the previous number; 20% improved to a lesser extent; 13% were unchanged; and only 4% became worse. Furthermore, in some cases the seizures *did not return* when Tridione was withdrawn. • Clinical investigations have also shown that Tridione is beneficial in certain psychomotor cases when combined with other antiepileptic therapy.[2] You may obtain Tridione in 0.3-Gm. capsules and in pleasant-tasting aqueous solution containing 0.15 Gm. per fluidrachm. Wish literature? Just drop a line to ABBOTT LABORATORIES, North Chicago, Ill.

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1. Lennox, W. G. (1947), Tridione in the Treatment of Epilepsy, J. Amer. Med. Assn., 134:138, May 10. 2. DeJong, R. N. (1946), Further Observations on the Use of Tridione in the Control of Psychomotor Attacks, Am. J. Psychiat., 103:162, Sept.

(Continued from Page 1370)

Range Fight on No. 1 Child-Killer Is Cited as Example for Other States."

The final five paragraphs of Dr. Rusk's illuminating story told specifically of the Michigan experiment:

"One of the most recent programs devoted to rheumatic fever to become statewide is that of Michigan. Developed within the last year and a half, the Michigan program, which is designed to provide a long-range procedure involving case finding, diagnosis, treatment, convalescent care and follow-up studies, is operated by the Michigan State Medical Society with the co-operative assistance of the Michigan Crippled Children Commission and the Michigan Society for Crippled Children and Disabled Adults. The state has been divided into districts, each with one or more centers, to which any physician in the state may send patients suspected of having rheumatic fever for diagnosis and consultative advice on treatment, prophylaxis and follow-up.

"The centers are staffed with medical specialists, who give liberally of their time, as the small examination fee is used to cover laboratory costs. Reports and recommendations then are made to the patient's family physician. In instances where a family cannot afford treatment costs are paid by the Michigan Crippled Children Commission. Borderline cases are provided for either in whole or in part by local units of the Michigan Society for Crippled Children and Disabled Adults, which bears the operational costs of the centers, or from other sources. Auxiliary services, such as stenographic assistance, nursing aid, transportation and lay education, are furnished by the alumnae of the Alpha Phi Sorority.

"Of the first 600 children through the clinics, nearly a third were found to have or to have had rheumatic fever. As the next step in the program, the Michigan Society for Crippled Children and Disabled Adults is establishing a convalescent home for children who no longer need hospitalization, but who are unable to receive the proper convalescent care in their homes.

"Though in its infancy, the Michigan program seems off to a good start toward its avowed objective of seeing that every case of rheumatic fever in the state is recognized and properly managed, regardless of the economic status of the patient's family.

"Increased basic and clinical research in the causes and methods of treatment of rheumatic fever and rheumatic heart disease are still sorely needed, but when all states have a program similar to that of Michigan, the first round against the nation's number one killer of school-age children will have been won."

THE TREATMENT OF MONOCULAR CONVERGENT SQUINT

"Doctors must realize that squint is curable in its incipiency and they must also be informed that it is difficult and often impossible to cure neglected cases. They must know also that neglected cases cannot be cured by a simple operation, and the mere fact that a cosmetic result is obtained does not mean a cure at all, but simply a relief of deformity. To advise a mother to let the child alone, he will grow out of it, means not only a lost eye as far as a useful functioning organ is concerned, but it usually means an expensive, tedious operation. We can assure you, this is the penalty suffered by following such advice. No physician worthy of the name would give this advice if he were better informed, and it is the duty of the oculist to teach his fellow practitioners these facts." (Quoted from Wilkinson, Oscar, and Richard W.: Strabismus, Its Etiology and Treatment. Meador Publishing Co., Boston, page 191.)—*Ohio State Medical Journal,* September, 1947.

CONFERENCE OF STATE MEDICAL ASSOCIATION SECRETARIES

(Continued from Page 1368)

told of the "Literary Aspects." He said most of our medical writing is wordy, could be vastly improved if we would weigh the phraseology and rewrite much of what we have written. John Storm, Executive Editor of *Hospitals,* had the subject "Editorials." He judged the editorials on four points: (1) purpose, interpretation of times and plans; (2) pattern, (3) readability, and (4) diligence of carrying out a policy. Some of the journals missed in one or more counts; others excelled in some counts. Morris Fishbein, M.D., Editor of the *Journal of the American Medical Association,* discussed "Scientific Material." He accused some of the state medical journals of publishing too scientific material, or too much of highly specialized material. He told of the paper written to be read at some medical meeting, but not written to be published. There is a difference, and he cautioned authors to bear that in mind when they are having papers published. He cautioned about useless words, and needless introductions.

The Secretaries, in their group meeting, discussed the question, "How Can the Activities of the American Medical Association and the State Medical Societies be Better Co-ordinated?" Speakers were Creighton Barker, M.D., secretary of the Connecticut State Medical Society, P. T. Talbot, M.D., secretary of the Louisiana State Medical Society, Charles S. Nelson, executive secretary of the Ohio State Medical Society, and Frank J. Milloy, M.D., secretary of the Arizona State Medical Society. General George F. Lull, secretary and general manager of the AMA, led the general discussion.

On Saturday, November 8, the moderators of the discussion groups reported their findings, and Louis H. Bauer, M.D., member of the Board of Trustees of the AMA, reported on the "World Medical Association" of which the AMA is a member. The WMA recently held a meeting in Paris, and completed its organization. The permanent secretariat will be in New York.

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For the Ninetieth time, Merry Christmas...from *Borden's*

For this merry season, may we wish you the best of everything . . . including the deep and abiding satisfaction that comes from worth-while work . . . well done!
We know this is a fine feeling, because we have enjoyed it, in a modest way, for 90 years. And we want to tell you, as sincerely as we know how, that in 1948 and the years after that we will continue to serve you and your patients to the very best of our ability.

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Editorial Comment

A SOUND MENTAL HEALTH PLAN

If the Michigan mental health commission carries through with its present plan to draft a new program for the care of the mentally ill, Gov. Sigler and the legislature may have to decide in the 1948 special session whether to emphasize prevention or hospitalization in the state's mental health program.

The commission's problem, as expressed by one of its members, Dr. Raymond W. Waggoner, who is also head of the neuropsychiatric institute at the University of Michigan, is to convince the legislature that prevention and prompt treatment of mental illness can reduce the need for beds in state hospitals. In view of the governor's and legislature's repeated assertion that more money is needed for hospital construction it isn't going to be easy to ignore Dr. Waggoner's statement that "if we could get the personnel we need, we could stop further hospital expansion right now."

The commission's program, of course, calls for more than just added personnel, although that is probably its most important point. More trained psychiatrists and psychiatric workers are needed before much can be done about such other features as setting up clinical centers in many areas for diagnosis and treatment and expanding family care programs.

The mental health unit is on firm ground in emphasizing the need for increased study opportunities, better living conditions and more adequate salaries to attract professional personnel. The fact is that the state is finding it difficult and even impossible on occasion to hire qualified psychiatrists, psychiatric workers and psychologists in various state institutions where they are badly needed because the hours are inordinately long and the pay is extremely modest compared with what the same persons can earn outside.

One solution to the present problem of relieving congestion in state hospitals is to go on building more hospitals indefinitely, at a consequent heavy expense to the taxpayer and a tremendous waste of human values. Another and more intelligent solution is to set up a statewide prevention and early treatment program. Admittedly, the latter takes far more foresight and careful planning than does the other—and that, we fear, is one of the principal reasons why it has been given so little attention in Michigan so far.—*Grand Rapids Press* (Michigan), October 13, 1947.

DOCTORS AND GIRDLES

Elastic is so scarce in Great Britain that a woman in need of a girdle must have a doctor's certificate to purchase one. The doctor certifies that her sacroiliac needs support and she gets the vital garment.

Equivocation? The doctors themselves admit that often it is, but say they are forced into it by the orders and regulations under which they are required to practice. British medical journals are engaged in a movement to oppose further regimentation. One article says: "Since the end of the war politicians have shown a growing reluctance to trust the individual, who, in the present vast and imposing machine of the state, is made to feel little more than a cog. He becomes a calorie-consuming unit; a man-hour producing mechanism.

Medical men approve the fight against proposed nationalization of the iron and steel industry, because they realize that every such struggle postpones for a while the socialization of medicine.

Most medical men in the United States are of the same mind as those in Britain. The personal equation, so vital in the relationship between doctor and patient, might become negligible under a socialized regime. Any tendency toward minimizing the importance of the individual is likely to be a tendency toward tyranny by a group.—Editorial, *Lorain Journal* (Ohio).

TYPHUS

About twelve years ago Doctor Hans Zinsser made this prophecy: "Typhus is not dead. It will live for centuries, and it will continue to break into the open whenever human stupidity and brutality give it a chance, as most likely they occasionally will. But its freedom of action is being restricted, and more and more it will be confined, like other savage creatures, in the zoological gardens of controlled diseases."—Stanhope Bayne-Jones, M.D., *Rhode Island Medical Journal,* June, 1947.

To Oral Effectiveness and High Potency

ADD...a "plus"

An increasing number of investigators are commenting on the general "sense of well-being" which is usually experienced by menopausal patients following "Premarin" administration. This is a "plus" in therapy which is most gratifying to the woman crossing the threshold of the climacteric.

"Premarin" is supplied as follows:
Tablets of 2.5 mg. . . . . bottles of 20 and 100
Tablets of 1.25 mg. . . . . bottles of 20, 100 and 1000
Tablets of 0.625 mg. . . . . bottles of 100 and 1000
Liquid, containing 0.625 mg. in each 4 cc. (1 teaspoonful) . . . bottles of 120 cc.

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ROUTINE CHEST X-RAYS

Taking the lead among the states in encouraging general hospitals to make routine chest x-rays of all their patients, Michigan now has twenty-two general hospitals which will x-ray all their 120,000 annual admissions through the use of equipment bought with federal funds and made available to the hospitals by the Bureau of Tuberculosis Control, Michigan Department of Health.

Equipment bought for the hospitals, four of which came into the program during the past year, cost $107,-402.97. Some hospitals were given complete equipment, and others items to supplement what they already had.

The Bureau of Tuberculosis Control decided to spend part of its federal grant-in-aid for tuberculosis control in providing equipment for general hospitals because there are more cases of tuberculosis found per one thousand persons examined among admissions to general hospitals than among any other group.

The participating hospitals are in fourteen major cities in the state. They have a bed capacity of 3,942 and total annual admissions of 120,080. These hospitals will x-ray each person admitted, not as a diagnostic study but to find those who have abnormal lung conditions.

The participating hospitals are: St. Joseph Mercy, Ann Arbor; Community and Leila Post, Battle Creek; Community, Coldwater; Receiving, Detroit; Blodgett, Butterworth and St. Mary's, Grand Rapids; Grandview General, Ironwood; Mercy, Jackson; Borgess and Bronson, Kalamazoo; Sparrow and St. Lawrence, Lansing; St. Luke's and St. Mary's, Marquette; Pontiac General, Pontiac; General, Port Huron; Saginaw General and St. Luke's, Saginaw; Munson, Traverse City; and Beyer, Ypsilanti.

AMA WILL HONOR GENERAL PRACTITIONER BY GOLD MEDAL

The Board of Trustees of the American Medical Association has established a special gold medal for a general practitioner who has rendered exceptional service to his community.

The award, similar to the American Medical Association's Distinguished Service Medal which has been given annually since 1938 for scientific advancement in the field of medicine, will be given to a general practitioner for the first time at the supplemental session of the House of Delegates at Cleveland, Ohio, on January 7, 1948.

Designed especially for the physician who has served his people as a family doctor and who does not devote himself exclusively to a specialty in medicine, the award will be known as "the medal of the American Medical Association for exceptional service by a general practitioner."

Nominations for the award may be submitted to the headquarters office of the American Medical Association in Chicago by any state medical association or community service club, such as a Rotary, Kiwanis or Lions Club, Chamber of Commerce, woman's club, community council or similar group. The nomination should include the name and address of the physician, his scholastic record and a record of his medical service in the community.

Nominations will be submitted to the executive committee of the Section on General Practice of Medicine of the American Medical Association, which is composed of Wingate M. Johnson, M.D., Winston-Salem, N. C.; Paul A. Davis, M.D., Akron, Ohio; and E. A. Royston, M.D., Los Angeles. This committee will select five leading candidates for nomination for submission to the Board of Trustees, which, in turn, will nominate three of these to the House of Delegates. On the opening day's meeting at the supplemental session, the House of Delegates will choose by ballot the general practitioner who will receive the medal.

IMPORTANT MEETINGS TO ATTEND

1. American Medical Association's Mid-Winter session, Statler Hotel, Cleveland, Ohio, January 5-6-7-8, 1948.
2. MSMS County Secretaries-Public Relations Conference, Book-Cadillac Hotel, Detroit, Sunday, January 25, 1948.
3. National Conference on Medical Service, Palmer House, Chicago, Sunday, February 8, 1948.
4. Second Annual Michigan Postgraduate Clinical Institute, Book-Cadillac Hotel, Detroit, Wednesday-Thursday-Friday, March 10-11-12, 1948.
5. 83rd Annual Session—Michigan State Medical Society, Book-Cadillac Hotel, Detroit, Wednesday-Thursday-Friday, September 22-23-24, 1948.

DUES OF STATE MEDICAL ASSOCIATIONS

Alabama, $20; Arizona, $50; California, $60; Colorado, $50; Connecticut, $20; District of Columbia, $30; Florida, $25; Idaho, $22; Illinois, $10; Indiana, $15; Iowa, $15; Kansas, $15; Kentucky, $15; Lousiana, $25; Maine, $35; Maryland, $20; Michigan, $37; Minnesota, $20; Missouri, $15; Montana, $25; Nebraska, $15; New Jersey, $25; New Mexico, $20; New York, $10; North Dakota, $35; Ohio, $15; Oklahoma, $42; Oregon, $40; Pennsylvania, $15; Rhode Island, $40; South Carolina, $20; South Dakota, $50; Tennessee, $20; Texas, $20; Utah, $50; Vermont, $35; Virginia, $25; Washington, $25; West Virginia, $15; Wisconsin, $33; Wyoming, $25.

FEES FOR MEDICAL SERVICES IN HOSPITALS

All hospitals have received copies of the AMA resolution, adopted by its House of Delegates last June in Atlantic City, advising "that all fees for medical services be set by and collected by and for doctors of medicine

(Continued on Page 1378)

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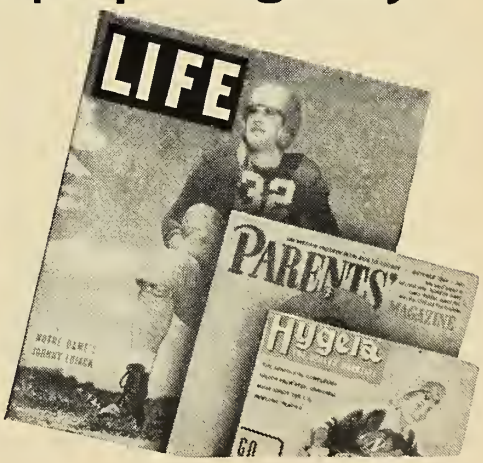

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FEES FOR MEDICAL SERVICES IN HOSPITALS

(Continued from Page 1376)

rendering this service, and that all policies and practices involving medical services be approved by the medical board or medical staff before being put into effect."

PREPAYMENT PLANS COVER 6,500,000 PERSONS

Medical Society sponsored prepayment plans are growing at the rate of 200,000 new subscribers each month. The national enrollment is now over the 6,500,000 mark. Michigan Medical Service has an enrollment of over 900,000 subscribers.

NEW AMERICAN MEDICAL DIRECTORY

The AMA will publish the 18th edition of the American Medical Directory in 1948. The 17th edition was issued late in 1942. Since that date it has been impossible to publish a new edition because of wartime restrictions and the shortage of paper and labor.

On November 15, 1947, a card was mailed to every doctor of medicine in the United States requesting information to be used in compling the new Directory. If any MSMS member failed to receive one of these Directory Information Cards, he should write at once to the AMA Directory Department, 535 N. Dearborn Street, Chicago 10, Illinois. This is important.

ANOTHER FEDERAL MEDICAL AGENCY LIQUIDATED

The Midwestern Agricultural Workers' Health Association, Inc. will cease active operation as of December 31, 1947. It is expected that it will take the month of January, 1948, to liquidate the Association and to pay all outstanding obligations. This Association was performed to provide medical care for foreign agricultural workers, as a war emergency program. Now that the emergency has ended, the government finds it unnecessary to import foreign agricultural workers.

It is important that all Doctors of Medicine who have rendered service for the Midwestern Agricultural Workers' Health Association present their statements for payment prior to January 31, 1948.

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*J. A. M. A. 129:1030. December 15, 1945.

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More Annual Session Echoes

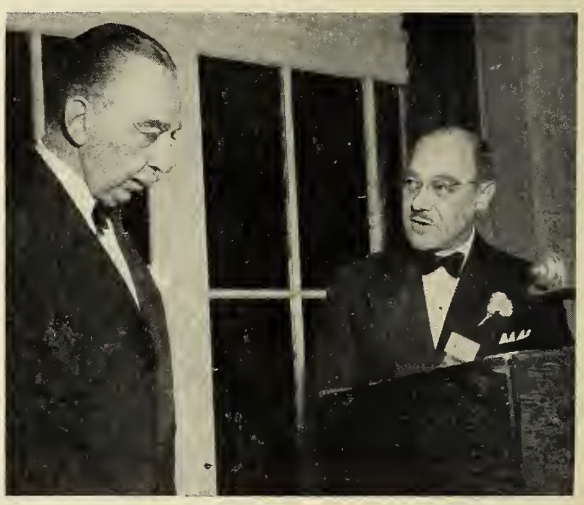
Ciba Pharmaceutical Products by H. M. Bilden, Summit, New Jersey: "Our representatives who were present at the Ciba booth during these days were very much pleased with the reception which they received. We here in Summit are pleased to note the high number of registrations which came in from this meeting. It is our desire to participate again at your meeting that will be held September 22-24, 1948, at the Book-Cadillac Hotel, Detroit."

H. G. Fischer & Co. by M. C. Hunt, Detroit: "This was a very satisfactory meeting from our standpoint, which we feel is due to your efficient efforts in the interest of both physicians and exhibitors. It was a pleasure for us to be present at this meeting and will be happy to participate in your 1948 meeting as an exhibitor.

"If such meetings throughout the country were as well managed as this one, I am sure exhibitors would have no grounds for complaint."

Professional Management by Henry C. Black, Battle Creek: "As usual, a well-conducted convention—the consistent excellence of the exhibit phase of the convention becomes so expected that repeated compliments almost seem out of order. We will wish space again next year, of course."

(Continued on Page 1433)



President's Key to Doctor Hyland

Wm. A. Hyland, M.D., Grand Rapids (*left*), is being presented with the Past President's Key by E. F. Sladek, M.D., Traverse City, Chairman of The Council (now President-elect). The presentation was made in Grand Rapids, September 24, 1947, during Officers' Night ceremonies on the occasion of the 82nd Annual Session MSMS.

Medical Officers' "Line-Up"

MSMS officers in the Hospitality Booth at the 82nd Annual Session, Grand Rapids, September, 1947

(*Left to right*): E. F. Sladek, M.D., Traverse City, President-Elect; P. L. Ledwidge, M.D., Detroit, President; C. E. Umphrey, M.D., Detroit, Councilor, First District; L. Fernald Foster, M.D., Bay City, Secretary; Wilfrid Haughey, M.D., Battle Creek, Editor and Councilor, Third District; J. Duane Miller, M.D., Grand Rapids, Councilor, Fifth District; Wm. A. Hyland, M.D., Grand Rapids, retiring President; and J. S. DeTar, M.D., Milan, Speaker, House of Delegates.

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Possible Infant Salvage at Florence Crittenton Hospital

By S. W. Trythall, M.D., F.A.C.S.
Detroit, Michigan

ONE CANNOT HELP being impressed by the attempts made to lessen the maternal fetal mortality rates in our hospitals. There are actively functioning committees on the interruption of pregnancy, on sterilization, and required consultations for performing cesarean sections. Early in 1947 there was established in our hospital, a resuscitation team to be in attendance at all possible viable premature and cesarean section deliveries for resuscitation of the newborn infant. As a contribution to the efforts being made for raising medical standards in this field, I am attempting to evaluate the potentially salvable infants over a five-year period at Florence Crittenton Hospital, the study to be finally completed in 1948.

The feeling has been that much could be learned that would provide a good working basis for future procedures, thereby hoping to show a lowered fetal mortality rate at a later date. The study will be definitely more valuable as a result of a money award at the end of each year to the resident securing the greatest number of autopsies, including infant deaths. Since the added interest in this problem, we have practically 100 per cent of the possible stillborns and neonatal deaths coming to necropsy.

Read before the Michigan Obstetrical and Gynecological Society, Detroit, Michigan, May 6, 1947.

The figures employed here are for the years 1944, 1945 and 1946 and do show by a careful study of the charts that a certain number of these infants could be saved.

In the prevention of neonatal accidents and birth injuries, we should briefly review a few of the maternal factors that contribute to these problems. The primary one is good prenatal care, which would include an absolute knowledge and familiarity with all of the abnormal findings in the patient's complete physical examination and history. Obstetrics, and the subsequent care of the newborn, becomes increasingly a problem of preventative medicine. With the advent of the sulfa drugs and penicillin to aid us in the treatment of intra-partum and the prenatal problems, we are confronted with the toxemias, erythroblastosis, atelectasis and frank brain hemorrhage as the real enemies of the newborn.

The relationship of the toxemias and kidney function to abruptios and stillborns is so vitally important that asking the patient if she has ever had any kidney trouble is not sufficient. Various inquiries such as, "Any complicated scarlet fever, any urgency, enuresis, frequency, and unexplained fevers of childhood," may suggest pyelitis or its fellow traveler, pyelonephritis, with diminished kidney function. Nocturias may indicate an inability to concentrate the urine. These patients, when seen early, give an excellent opportunity to do catheterizations and concentration tests, such as the Mosenthal or Fishberg routines to establish, in at least a rough manner, the kidney status. The tests are easily done by simple laboratory procedure without added expense to the patient.

We do not know the cause of the true toxemia and, hence, nothing of its cure. We do know that by attempting to establish kidney function early in

the nephritic, we are able to try to prevent, and frequently do, the toxemias, subsequent abruptio, and stillborns. We have two sharp weapons that can be used effectively: water balance and early weight gain. The importance of this problem to the mother and newborn is so great that the doctor must spend his time and his energy with each patient, especially those in the lower intelligence group, to the extent of outlining, when necessary, each meal and charting the intake and output with the patient.

This much, then, to stress that the solving of many problems of infant salvage begins with the patient's initial visit, and that infant mortality rates can best be lowered by sound, carefully detailed, prenatal care, and that obstetrics and its adjunct, the care of the newborn child, are within the confines of preventive medicine. In this three-year study of possible salvable infants at Florence Crittenton Hospital, one finds that toxemias entered the picture in 39 per cent of the cases.

Intracranial damage was one of the common and most serious contributors to infant mortality. The tears visible at autopsy in frank brain hemorrhage, the grunting respirations and intermittent cyanosis of the atelectatics present such similar clinical findings that anoxia is considered as one of the principal causes of atelectasis. One frequently finds these groups in the premature nursery. Our study shows that the causes of brain damage were found to be, in order of their importance:

1. Prematurity.
2. Difficult operative deliveries.
3. Rapid passage through the birth canal, such as with the after-coming heads of breeches, pituitrin stimulated labors, and precipitate labors.

The drug houses encouraged us to believe that vitamin K would solve many of our intracranial problems, but Dr. Potter of Chicago, in an extensive and well-controlled investigation, believes that no decrease in infant or fetal mortality can be expected to result from the routine administration of vitamin K.

In this study one is confronted with a premature incidence of 58 per cent; the premature being defined as the infant 1,000 to 2,500 grams or 35 to 50 cm. in length, without regard to the duration of pregnancy.

Dr. Dana of Cornell estimates in her study that prematurity is a primary cause of 18 per cent of all neonatal deaths and an associated factor in an additional 22 per cent, using 1,500 grams as a basis of viability. The decrease of mortality in the premature will rest with the pediatrician, but it is up to us to deliver the premature with the best possible technique. The causes of infant mortality, such as erythroblastosis, multiple birth, malformation, and environment, are beyond the control of the obstetrician. His job is one of watching the control of syphilis, acute febrile diseases, and continued toxemia research. The incidence of prematurity has remained fairly constant the past twelve years at the Columbia Medical Center, but better delivery and improved labor techniques have increased the survival rate to about 50 per cent.

In Dr. Beck's studies of prematurity, he finds the obstetrician responsible for about 60 per cent of neonatal deaths, which would include that portion of infant mortality caused by intermittent cyanosis, brain hemorrhage and infection.

Our study reveals, as is the generally accepted fact, that it will be from working with the prematures in this group that we might hope to increase our infant salvage. In a five-year survey of Long Island College Hospital, an average fetal and neonatal mortality is reported as 2.63 per cent. For the years 1943-46, we can report a percentage of 2.83 per cent. We are envious of the fact that they are able immediately to consign their newborn to an active pediatric service.

An analysis of the charts for the years under consideration makes these figures available (Table I).

I have studied each case minutely with one fixed purpose: that of lowering fetal and neonatal mortality at Florence Crittenton Hospital and increasing the salvage rate of prematures.

To summarize, twenty-three monstrosities, incompatible with life, were discarded; fifty-seven reported deliveries of less than 1,000 grams are not included in the calculations; twenty-nine macerated stillbirths, resulting chiefly from toxemias and placental separation were not considered redeemable; sixty-four infants in this three-year study were considered salvable.

Table II shows the factors that were concerned in these stillborn and neonatal deaths.

A fetal and infant mortality rate of 2.83 per cent in comparison with many hospitals is an acceptable figure, but it does not approach, in our hospital, the irreducible minimum. It will be the absolute

attention to every minute detail in every case and a concern over infant mortality, as that found in maternal deaths, which will produce a lower figure.

TABLE I. FLORENCE CRITTENTON HOSPITAL

Year	Total Delivery	Infants 1000 Gm. or Over	Stillborn Macerated Fetus	Monsters Incompatible With Life	Possible Salvable Infants		Total Fetal and Neonatal Deaths	Per Cent Fetal and Infant Mortality
1944	1654	1640	6	7	25 / 1.52%	Pre. 10 / 40%	38	2.26
1945	1333	1327	9	12	18 / 1.31%	Pre. 12 / 70%	39	3.00
1946	1764	1734	14	4	21 / 1.21%	Pre. 14 / 65%	39	2.24
Totals	4751	4701	29	23	64 / 1.33%		116	2.83

TABLE II. FACTORS CONCERNED IN THE POSSIBLE SALVABLE INFANTS

Year	No.		Atelectasis	Frank Brain Hemorrhage (Autopsy)	Toxemias	Post Maturity	Prolapsed Cord	Placental Separation	Breech 70/40	Diabetes	Unknown
1944	10	Premature	4	7	3	0	1	3	2	1	1
	15	Term	1	4	6	1	1	2	1	0	2
	25	Total									
1945	12	Premature	8	1	1	0	0	2	2	0	0
	6	Term	3	2	3	2	2	0	0	1	0
	18	Total									
1946	14	Premature	6	6	4	0	0	5	4	0	0
	7	Term	4	4	8	3	3	3	1	2	1
	21	Total									

With a new survey in view, we have discussed with our residents, the possibilities of a higher salvage rate, and as a basis, then, for their study and future practice, we have asked for:

A. A more strict attention to rupture of membranes in non-engaged presentations, i.e., immediate examination for the prolapsed cord.

B. An aseptic vaginal examination in nonprogressing, nonexaminable patients before crises. It is certainly less contaminating than dozens of rectals, and immediate proper treatment could be instituted.

C. A more wholesome respect for the premature by:

1. Detailed prenatal care which would include the patient's reporting at once any unusual symptoms.

2. Elimination of sedation and general anesthetics. Cole, Kimball and Daniels, in 5,000 cases, showed that anoxia was in direct relation to the depth of sedation and that any amount of general anesthesia produces anoxia in direct proportion to the length of anesthesia. Irving, Burman and Nelson demonstrated that 98 per cent of infants cried spontaneously without general anesthesia or analgesia.

3. Doing deep episiotomies in all possible viable prematures with preservation of the membranes

as long as possible—using outlet forceps if delivery is delayed.

4. Postpone tying of the cord. Dr. White at Ford's, and others, have demonstrated the increased blood supply to the fetus by waiting for a cessation of pulsation, or if you are impatient, waiting for two minutes. During this time, the baby must be kept in warm sterile blankets.

5. Prompt recognition of anoxia by the change to a mustard meconium, irregular fast fetal heart, (above 160) and an extremely agitated fetus. The doctor should be notified at once and delivery completed as soon as possible, utilizing skillful resuscitation with heat, intratracheal clearing and oxygen introduced into the bronchial tree, and avoiding coramine, metrazol and alpha-lobeline, especially in the anoxic patient.

6. The premature baby should be transferred at once to a previously prepared incubator without examination, and often without tying the cord. Too frequently, the importance of this is forgotten as well as nursing care around the clock. The optimum temperature of 80° to 85° is maintained for infants over 4.5 pounds, and 85° to 90° for the lesser weights. Poor muscles, poor heat mechanism and no insulation make temperature regulation important. The humidity should be maintained between 50 and 60 per cent. You must check this yourself. Too many times, hours following delivery, one finds the oxygen not turned on and the incubator still cold.

7. Strict asepsis of the nursery and formula room is mandatory.

8. The use of a more skilled delivery technique in the frequently appearing breech, which is as high as 50 per cent of the prematures in some clinics. In some cases a Voorhees bag against the cervix may delay delivery until adequate cervical dilatation is present. Dührseen's incisions of the cervix to allow the larger after-coming head is a recognized procedure because one cannot successfully drag an after-coming head through a rigid cervical cuff.

9. By prompt introduction of chemotherapy with evidence of intra-partum infection in the particularly susceptible premature. The University of Pennsylvania has shown that with proper penicillin dosage, maternal amniotic and fetal levels are the same. The therapy should be continued after delivery.

10. By establishing a frozen breast-milk bank.

D. The resident on service must prepare a detailed report on all stillborns or neonatal deaths of infants born whose weight exceeds 1,000 grams. It is similar to that required on all maternal mortality, and they are all reviewed by the obstetrical and gynecological department.

References

1. Beck, Alfred C.: Obstetricians responsibility for the first few days of life. Am. J. Obst. & Gynec., 51:173-183, (Feb.) 1946.
2. Cole, W. C., Kimball, and Daniels, L. E.: Etiologic factors in neonatal asphyxia. J.A.M.A., 113:2038-46, (Dec.) 1939.
3. Dana, Ethel: Premature delivery. Am. J. Obst. & Gynec., 51: 329-42, (March) 1946.
4. Dieckmann, W. J.; Turner, D., and Ruby, B.: Diet regulation and controlled weight in pregnancy. Am. J. Obst. & Gynec., 50:701-12, (Dec.) 1945.
5. Dugold, Baird: Influence of sound and economic factors on stillbirths and neonatal deaths. Am. J. Obst. & Gynec., 52:359, (Sept.) 1946.
6. Irving, F. C.; Berman, S., and Nelson, H. B.: The barbiturates and other hypnotics in labor. Surg., Gynec. & Obst., 58:1-11, (Jan.) 1934.
7. Mengert, William: Postgraduate Obstetrics. Pp. 287-98. New York: P. B. Hoeber, Inc., 1947.
8. Potter, E.: The effects of infant mortality of vitamin K administered during labor. Am. J. Obst. & Gynec., 50:235-47, (Sept.) 1945.
9. Power, H. A., and Cravotta, C.: Penicillin in obstetrics. Am. J. Obst. & Gynec., 51:230-34, (Feb.) 1946.
10. Schrieber, F.: Apnea of newborn and associated cerebral injury. J.A.M.A., 111:1263-1269, (Oct.) 1938.
11. Woltz, H. E., and Zintel, H. A.: Transmission of penicillin to aminotic fluid and fetal blood in the human. Am. J. Obst. & Gynec., 50:338-9, (Sept.) 1945.

MSMS

STOP—LOOK—LISTEN

STOP telling the patient there is nothing wrong with him but nerves—Don't say: Go home and forget it.

LOOK for the facts as the patient sees them.

LISTEN attentively to patient's story.

* * *

Seventy-five to 80 per cent of organic illnesses have unhealthy psychic components.

Psychosomatic symptoms arise from being unable to solve emotional conflicts arising from disturbing situations. These conflicts may be recent, but in many cases are of remote origin.

Sedation for the psychoneurotic is only a crutch to help him stagger along.

The important thing is how the patient feels about unsolved problems or frustrations.

The Rational Use of Diuretics in Congestive Heart Failure

By E. H. Drake, M.D.
Detroit, Michigan

THE INTELLIGENT USE of diuretics occupies a place of prime importance in the management of heart disease. Some knowledge of the available preparations with an understanding of the physiological basis for their action is a requisite for any physician called upon to treat patients with congestive failure.

Useful diuretics are those drugs which mobilize, aid in the elimination, and prevent the recurrent collection of edema fluid within the body. Although they are employed in many disease states accompanied by edema, this discussion will be confined to their use in the edema resulting from failure of the circulation. Since edema fluid is eliminated through the kidney, the effectiveness of any diuretic substance will be partially dependent upon the number of effective filtration units or glomeruli plus the sum total of factors which determine the state of the renal circulation. Once the filtrate has passed into Bowman's capsule, the degree to which it is reabsorbed in the tubules will depend upon the electrolyte content and the amount of water that the body can spare which, in turn, will be governed by the salt content of the diet and the fluid intake.[12] In this connection Schemm has pointed out that water itself is actually a diuretic when administered in connection with a diet low in salt and with a neutral or acid ash.[27] With the above in mind, we find that diuretics may roughly be divided into two large groups: those that act by improving the state of the circulation in general and consequently of the renal circulation, such as digitalis and the xanthine derivatives which cause an increase in the glomerular filtrate; and those that act by diminishing the tubular reabsorption, such as the mercurials and possibly the xanthines.[7,12,13] In addition, we also find acting as diuretics certain threshold substances which are quickly eliminated by way of the urine. One of the most common drugs which acts in this manner is urea.

Read before the Detroit Heart Club, June 25, 1947.

Indications

Since diuretics are directed toward only one manifestation of congestive heart failure, they are usually employed in conjunction with other measures, such as restriction of activity, regulation of salt and fluid intake, and the intelligent use of digitalis.[12,23] Recent investigations have shown that there is no longer a rational basis for rigid fluid restriction in the management of congestive failure.[8,27,28,29,30] On the other hand, forcing fluids above and beyond the actual desires of the patient is advocated by some but is not generally accepted practice. Usually a total intake of from 1,700 c.c. to 2,700 c.c. daily is well tolerated by the patient.[19] A larger amount may cause gastrointestinal disturbances, while less may make the patient suffer from thirst and invite nitrogen retention. The clinical response to diuresis varies considerably with the underlying etiological basis of the heart disease. In chronic right ventricular failure of rheumatic etiology, diuretics may be required only at a later stage but usually remain effective for longer.[18] In failure secondary to constrictive pericarditis, beriberi heart disease, and thyrotoxic heart disease, diuretics are of relatively less importance and should not be used to delay or replace the institution of specific therapy. In acute and chronic cor pulmonale the response to diuretics, as to other therapeutic measures, is poor.[18] Diuretics are useful in left ventricular failure, both to treat the acute attacks, and in the chronic phase to prevent the recurrent episodes of pulmonary edema.[17] It might be well to mention several circumstances where diuretics may be judiciously used independently of the effects of digitalis. These include the failure occurring in connection with rheumatic fever and other acute infections, in the failure which often follows directly after the initial effects of acute myocardial infarction, and in pulmonary edema associated with the early stages of mitral stenosis where the use of digitalis, at least theoretically, may increase the degree of pulmonary congestion.

Where possible, large collections of chest and abdominal fluids should be removed mechanically prior to the institution of diuretic therapy.[18]

Classifications

Xanthines.—These drugs act chiefly by increasing the volume of the glomerular filtrate although Blumgart has stated that they also decrease tubular absorption.[5,12] They may be administered parenterally but are usually employed orally in daily maintenance dosage. In addition to their diuretic effect they are also important for their action on the general circulation and on the coronary arteries.[7] The preparations used most commonly today are listed below:

Drug	*Composition*	*Dosage*
Diuretin	theobromine sodium salicylate (52% salicylate)	0.5 to 1.0 gram, 4 × daily
Theocalcin	theobromine calcium salicylate (37% salicylate)	0.5 to 1.0 gram, 4 × daily
Phyllicin	theophylline calcium salicylate (50% salicylate)	0.25 gram 4 × daily
Thesodate	theobromine sodium acetate	0.5 gram 4 × daily
Calpurate	calcium theobromine } equal parts of each in double salt	0.5 to 1.0 gram, 4 × daily
	calcium gluconate }	
Glucophylline	theophylline—1.18 grains methylglucamine—1.16 grains	1 tablet, 3-4 × daily
Theocin	theophylline	0.1 to 0.2 gram, 4 × daily
Aminophylline	theophylline ethylene diamine	0.2 gram, 4 × daily
Theacitin	theophylline sodium acetate	0.3 gram, 4 × daily
Theamin	theophylline monoethanolamine	0.2 gram, 4 × daily

Many of these are available for injection and some are supplied in suppository form.

Toxic symptoms of the xanthines are principally of gastrointestinal origin and include anorexia, nausea, and vomiting. These may be minimized by giving the oral preparations on a full stomach. Enteric coated tablets are less irritating but absorption is often inconstant and not infrequently patients will state that they pass the tablets intact in the stools.[7]

Acids and Acid Producing Salts.—These preparations are rarely used alone for diuresis as the large doses necessary to accomplish results are often not well tolerated. (For example, from 10 to 20 grams daily of calicum chloride.) They may be used in maintenance dosages to prevent accumulation of edema fluid and are a valuable preparatory medication to augment the action of the mercurials.[21]

Acids and their salts are administered orally, are readily absorbed, and are quickly unloaded into the urine taking fluids with them.[12] They are also effective in mobilizing sodium by neutralization of the bicarbonate fraction of the alkaline edema fluid.[27,28,29]. The compounds in common use are as follows:

Drug	*Dosage*
Dilute HCl	To 60 gtts daily in divided doses. *(The usual precaution of administration through a glass straw should be used to safeguard the teeth)*
Ammonium chloride	0.5 to 1.0 gram, 4-6 × daily
Ammonium nitrate	0.6 to 1.3 grams, 4 × daily
Ammonium sulfate	0.3 to 1.3 grams, 4 × daily
Magnesium sulfate	4 to 16 c.c.
Calcium chloride	0.6 to 1.3 grams, 4 × daily
Potassium nitrate and other potassium salts	0.3 to 1.3 grams, 4 × daily

These compounds may likewise be irritating to the gastrointestinal mucosa and are also available in enteric coated tablets. It should be borne in mind that they may produce alarming acidosis especially in the face of renal failure, and blood carbon dioxide combining-power determinations should be made from time to time where such a condition is suspected. By production of prolonged vomiting, they are also capable of producing alkalosis. It is not considered desirable by most authorities to administer calcium or potassium salts, especially by the parenteral route, to digitalized patients.[36]

Mercurials.—These compounds, which are the most potent and effective of our modern diuretic agents, act by diminishing the tubular reabsorbtion.[12] While calomel once enjoyed considerable popularity as a diuretic, it has long since been discarded in favor of the more efficient preparations. The common mercurial diuretics now used include:

Drug	*Composition*
Salyrgan—(Mersalyl), 10% solution *Available in combination of two parts Salyrgan to one part theophylline*	39.6 mg. of mercury per c.c.
Mercupurin—(Novurit, Mercuphylline, Mercuxanthen), 13.5% solution 100 mg. of mercurin with	39.6 mg. of mercury per c.c. 39.0 mg. of mercury per c.c. 35.3 mg. of theophylline
Mercuhydrin	39.0 mg. of mercury per c.c. 18.0 mg.
Merbophen (Novasurol) Double salt of sodium mercuri chlorophenyl oxyacetate with barbital	33.93 mg. of mercury per c.c. 31.14 mg. of barbital

The addition of theophylline to the mercurial salts increases their rate of absorbtion, enhances their diuretic effect, decreases their toxicity and reduces the local irritating properties.[24] Of the compounds listed above, mercuhydrin has the advantage of being less irritating locally and is the one most suitable for intramuscular injection.[16]

The mercurials are usually administered intravenously. The first dose should be small, 0.5 c.c. or less, since the initial effect on the plasma volume of individual patients is unpredictable.[34] Subsequent injections may be of 1 or 2 c.c. and may be given at intervals to suit the needs

of the patient. If the edema is marked the dose may be repeated daily.[33] Some authorities believe that a more even diuresis is achieved by 0.5 c.c. doses given three times a day.[34] Single injections should be administered early in the morning in order that most of the diuretic effect may be dissipated by night.

Intramuscular injections should be given deep into the gluteal muscles. A local anesthetic may be added to the injection to minimize the local irritating effects. Suppositories are available which contain the equivalent of 200 mg. of mercury. They should be preceded by a cleansing enema, and an analgesic rectal suppository may be given prior to the diuretic preparation if desired.[33]

Recently, the oral administration of mercury for diuresis has become quite popular.[6,10] This method should theoretically provide an even diuresis and may be useful in those cases where the patient is not able to come to the physician for injections at frequent intervals. One tablet on the market supplies 100 mg. of mercurin powder containing 37 mg. of mercury combined with 27 mg. of anhydrous theophylline.* Several schemes of administration have been used in various clinics.

Single Dose Method.—This consists of a single dose of five tablets. Diuresis usually begins in four to twelve hours and is complete in twenty-four. Single doses are not particularly efficient, however, producing a three pound weight loss within forty-eight hours in only 60 per cent of patients without the previous administration of acid salts. This result does not begin to approach the efficiency of the intravenous administration.[2]

Multiple Dose Method.—This consists in administering one to three tablets three times daily for three to five days. It is not suitable where rapid results are desired, but may be useful when parenteral administration is not practicable. The total diuretic result by this method approaches that of an intramuscular injection.[2]

Method

Continuous Dose.—This method consists in giving one to two tablets daily for extended periods with a rest period of one week out of every four or five. The initial diuretic effect begins to appear in four to fourteen days, and during the first few weeks parenteral supplemental doses may have to be given, although DeGraff warns that these should not exceed 1 c.c. in volume.[14] A slow even diuresis is usually produced.[6]

Oral administration by the single or multiple dose method may be profitably used to lessen the number of clinic visits of those patients requiring frequent injections of the mercurials.[2] The patient may be supplied with the tablets and instructed to substitute oral diuresis for every other, or for two out of three of their usual injections. The need for continuous observation makes it inadvisable to allow the clinic visits to become too infrequent. However, we have found oral administration by the continuous method to be useful in only a small percentage of cases. The large amount of mercury absorbed has produced toxic manifestations, usually soreness of the mouth or diarrhea, in a rather large number of patients in whom the method has been tried. In addition, it has been shown that toxic effects on the heart are possible with very low concentrations of mercury in the blood provided they are maintained for a sufficiently long period of time.[35] For the patients who do not become toxic it may prove ideal. We have recently treated several patients who reaccumulated their edema fluid so rapidly between injections that they remained incapacitated much of the time, yet who were able to resume gainful occupations when switched to the even diuretic effect achieved by the continuous oral method. One of our cases has been benefited to the extent that he has continued to use two tablets daily without rest periods, despite our instructions to the contrary, for a period of twenty-six months. Repeated laboratory examinations have failed to reveal evidence of renal damage, and he has exhibited no toxic manifestations. However, the oral route, regardless of the scheme of administration, is relatively inefficient and means less diuresis per milligram of mercury than when the diuretic is given parenterally. The oral route is never effective when there is no response to parenteral injections.[2,3]

Effectiveness of Mercurial Diuretics.—Finklestein and Smyth recently published figures which showed 2.65 pounds as the average weight loss following an intramuscular injection of 1 c.c. of mercuhydrin, with a loss of 2.26 pounds following an intravenous dose of similar size. With an injection of 2 c.c. the losses were 3.56 and 3.23

*Campbell Products, Inc.

pounds respectively. If the injections were preceded by an ammonium chloride preparatory period, 1 c.c. of mercuhydrin intramuscularly gave a 4.66 pound weight loss—intravenously 5.80 pounds.

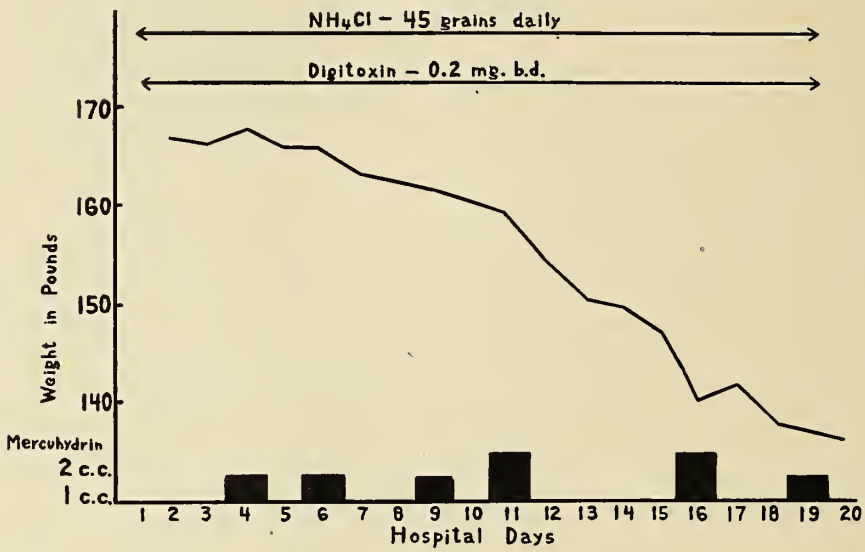

Fig. 1.

Two cubic centimeters intramuscularly gave 11.25 pounds—intravenously 8.27 pounds. Five tablets of the oral preparations in the hands of the same authors resulted in a weight loss of 2.61 pounds; while if the injection was preceded by eight grams of ammonium chloride daily for three days, the weight loss was 3.46 pounds.[16]

The following case history illustrates the way mercurial diuretics may be used in treating congestive heart failure with massive edema.

Case Report

M.B., a housewife, aged forty-three, was admitted to the Henry Ford Hospital on January 25, 1947. She had been married for twenty-one years and had seven children and one miscarriage. A diagnosis of "heart trouble" had been made on physical examination sixteen years previously. She had had scarletina at the age of three and on three occasions had swelling and tenderness in the right knee. Five years prior to admission she had begun to have ankle edema, two years later had noted frequency and burning with hematuria and occasional hemoptyses. During the next year she was digitalized, and for five months prior to admission had noted almost continual distention of the abdomen associated with cough and ankle edema. In the process of investigation of her hematuria, a double pelvis and ureter on the right was repaired surgically in 1943. Since that time she had noted occasional incontinence with cough. Highest weight was 295 pounds in 1937—present weight 165 pounds.

Entrance examination revealed an obese female in obvious distress. Moderate dyspnea and 1+ cyanosis were present. The patient was perspiring profusely and exhibited marked distention of the veins of the upper portion of the body. There was a perforation of the nasal septum and a hazing of the left antrum. A definite flush was present over the malar eminences and the pharynx was mildly injected. The retinal veins were engorged and the arterioles tortuous. The R.C.D. was located 12.5 cm. to the left in the fifth interspace, and a diffuse, heaving apex impulse was noted. The rate was regular, 28 to the quarter, and a presystolic gallop was present. There was a rumbling diastolic murmur at the apex followed by a presystolic accentuation and a prominent M1. A faint diastolic murmur was also audible along the left sternal border. Definite impairment and limitation of motion was noted at both lung bases with moist basal râles present bilaterally. The liver was tender and extended to the iliac crest. A fluid wave was present. Ankles and sacrum showed 3+ pitting edema. Blood pressure was 200/145.

Laboratory work at the time of admission showed: negative Kline exclusion test; urine albumin 2+, specific gravity 1.018, with 2+ hyaline casts; blood nonprotein nitrogen 38 mg. per cent, sugar 72 mg. per cent, hemoglolin 15.4 gm. per 100 c.c., red blood cells 4,670,000, white blood cells 10,400, with a differential count of 87 per cent polymorphonuclears and 13 per cent small lymphocytes. The cephalin-cholesterol liver function test was negative, and the thymol turbidity was 1 u, with thymol flocculation negative. Subsequent urine examinations revealed specific gravities ranging from 1.002 to 1.010, all specimens having albumin and casts.

The electrocardiogram showed a rate of 97, PR time 0.20 sec., QRS time 0.09 sec. There was a moderate degree of right axis deviation and large P waves in leads 2 and 3 with a diphasic T wave in lead 1 and an inverted T3. The unipolar extremity leads of Wilson revealed abnormally large P waves in leads V1, V2, and V3 with diphasic T waves in leads V2-V6 (later becoming upright). The ST segment in lead V6 was depressed. Occasional extra-systoles of auricular origin were present.

Cardiac fluoroscopy revealed generalized cardiac enlargement with marked prominence of the left auricle and pulmonary conus. A diagram of advanced myocardial insufficiency on the basis of rheumatic heart disease complicated by hypertension was made.

Course during hospitalization is shown in Figure 1.

Blood pressures during her stay ranged from 140 to 245 systolic and from 90 to 130 diastolic.

A very satisfactory weight loss was obtained by a combination of bed rest, low salt diet, adequate digitalization and mercurial diuresis. After discharge, she was satisfactorily maintained with periodic injections of mercurials in the outpatient department.

Contraindications

There are few contraindications to the use of the mercurial diuretics. The benefits to be derived from their use in patients whose lives are endangered by collection of edema fluid far exceed the dangers involved in the great majority of cases.[4] There are, however, a few situations in which the hazards from mercurial administration are markedly increased. Most of the contraindications listed below are relative in the sense that in each case the need for diuresis must be judged in terms of the inevitable results if edema fluid is allowed to accumulate unchecked.

1. Active glomerulonephritis with blood in the urine. Here care must be taken to differentiate the urinary findings of acute nephritis from those that result merely from passive congestion secondary to congestive failure. In the latter condition, it is common to find hyaline casts, albumin, and a few red blood cells in the urinary sediment.[17,18,33]
2. Marked impairment of renal function with a fixation of the specific gravity of the urine at 1.010 or less.[17,18]
3. Semimoribund patients regardless of renal function. The use of any drug in this situation is dangerous. The possible benefits should be compared with the danger of death occurring as a result of, or simultaneously with, the injection of the diuretic. This situation undoubtedly accounts for many of the so-called "mercury deaths."[18]
4. Rapidly increasing albuminuria or rising nonprotein nitrogen while under treatment.[2,3]
5. The occurrence of major toxic reactions. A fatal reaction is often preceded by a non-fatal one.[3]
6. Enterocolitis, diarrhea, and hemorrhoids[33] contraindicate the use of mercurial suppositories.

It should be pointed out here that an elevation of the blood nonprotein nitrogen in itself is not a contraindication to the use of mercurials. In older patients the drugs should be used with extreme care, since in men with prostatic hypertrophy their use may precipitate acute obstruction. In selected cases, it is well to institute catheter drainage prior to administration.[18]

Reactions

Toxic Reactions.—Deaths directly attributable to the administration of mercurial diuretics are relatively infrequent, although there have been several instances reported recently in the literature.[1,4,15,22] In all, accounts of about thirty-two authenticated cases have appeared in the past twenty-two years, all following intravenous administration. It has been pointed out that if deaths from the mercurial diuretics occurred in the same proportion as do deaths following the injection of arsenicals in the treatment of syphilis, we might expect about 100 per year.[14,15] Bellevue hospital reports that about 6,000 mercurial injections are given yearly with no deaths for the past eight years.[15] Wayne County (Mich.) Hospital administers about 1,500 ampoules yearly with no deaths during the past six years.[16] In the outpatient clinic of the cardiorespiratory division of the Henry Ford Hospital, about 8,000 injections have been given over the past ten years without a death. On the other hand, at Boston City Hospital, 5,200 ampoules of mercupurin were issued in sixteen months and two fatalities occurred.[35]

Clinical Manifestations.—Toxic reactions may be divided into the immediate and the delayed types.[2] The former are usually considered as being due to direct action of the drug on the cardiac muscle.[4,14,15,35] The serious reactions are manifested by dyspnea, cyanosis or pallor, irregular breathing, and a drop in blood pressure. Arhythmias may develop. In a very small percentage of cases there may be coma, convulsions and occasionally a fatal outcome. More often the immediate reactions follow a milder course. There may be a sense of apprehension with or without substernal discomfort and transient dyspnea. Orthopnea, cyanosis, and sweating often occur, and there is usually some degree of tachycardia.[35]

Delayed reactions are also of two types. In those occurring one to two hours following the injection, the manifestations are primarily pulmonary with asthma and some degree of pulmonary edema. The reactions coming on six to twelve hours after injections are characterized by varying degrees of weakness, apathy, muscle cramps,

tetany, and mental confusion sometimes progressing to delirium.[12] Actual coma and death are uncommon. This type of reaction is usually secondary to a disturbance of the electrolyte and plasma volume balance and is more common in older individuals following a vigorous diuresis or where the environmental temperature is high. It is associated with hypochloremia and azotemia.[4,35]

In certain patients who are hypersensitive to mercury, allergy may develop when a certain threshold concentration in the blood stream is reached.[4] Burrows and Stokes have pointed out that patch tests may be valuable in discovering sensitive individuals.[9]

It is not uncommon for cardiac patients with congestive failure to exhibit signs and symptoms of digitalis toxicity following vigorous diuresis.[3,12] These are usually not serious and consist of nausea and vomiting, ventricular extra-systoles, bigeminal rhythm, et cetera.[15] Some authorities consider it wise to attempt to prevent such occurrences by eliminating the daily dose of digitalis for one or two days prior to the injection, but this is usually not necessary.

Mercurialism may be encountered, especially with the continuous method of oral administration, where relatively large amounts of mercury are absorbed. The symptoms relate primarily to the gastrointestinal tract and include gingivitis, nausea, vomiting, and diarrhea, although evidence of renal irritation including elevation of the blood nonprotein nitrogen may occur.[3,12]

Since the mercurials are quite irritating if allowed to come into contact with the tissues, thromboses and sloughs may result if the material is injected outside of the vein.[18] As pointed out above, mercuhydrin may safely be given intramuscularly but should only be administered by deep injection, preferably into the gluteal muscles.

The following suggestions may be helpful in treating and preventing reactions:

Prophylactic.

1. Give all injections slowly; start with small doses and dilute well.[33]

2. If the condition of the patient will permit, allow a sufficient interval between injections. Reactions occur more frequently where injections are given before the effects of the previous dose have completely worn off.

3. Mix with materials that have been shown to detoxify. This will aid particularly in reducing the incidence of immediate reactions. Some of the detoxifying agents which may also augment diuresis include 0.5 c.c. of magnesium sulfate, vitamin C, and members of the B complex group.[25,31,32]

4. Decrease the dose or increase the interval between injections during periods of high environmental temperature.[14,15]

5. Recognize reactions when they occur. Get an accurate history from patients who have previously received mercurials.[18]

6. Be aware of the contraindications. Evaluate renal function.[15,18]

7. Consider omitting the maintenance dose of digitalis for one or two days preceding the injection.[15,18]

8. When sensitivity has been demonstrated, cautiously try a different mercurial compound.[15,18,35]

9. Avoid the use of mercurials simultaneously with morphine.[33]

Treatment.

1. Parenteral fluids, saline, and vitamin B complex will prove beneficial especially in the delayed type.[18]

2. Marshall has recently suggested that the occasional appearance of tetany may be due to a borderline calcium deficiency and has advocated the use of oral and parenteral calcium even in the fully digitalized patient.[20]

Some mention should be made of certain other miscellaneous compounds sometimes used as diuretics. Urea may be given for several days following the mercurial injections to combat the postdiuretic oliguria. It may be administered in divided doses totaling 20 to 85 grams daily disguised in fruit juices or coffee.[12] Urea is a threshold substance which is promptly eliminated in the urine carrying water with it. Its use is contraindicated in blood urea nitrogen elevation.[12]

Decholin (a 10 per cent solution of sodium dehydrocholate) is employed in 5 to 10 c.c. doses as a vehicle to augment the action of the mercurials. Herrmann, Dechard, and associates showed that decholin plus mercupurin gave an 878.0 per cent total average increase in urinary output after three days, while the same dose of mercupurin alone gave 707.0 per cent.[26]

Bismuth and arsenic salts have diuretic properties but are inferior to the mercurials.[36]

Parathyroid hormone acts as a diuretic, possibly by its action in mobilizing calcium, but is not

employed clinically in this capacity at the present time.[33]

Summary

The physiological properties and modes of action of the various common diuretic agents are discussed. Representative compounds in each of the major groups are listed and suggestions made as to their proper dosage and mode of administration. Toxic properties of the mercurials are outlined, together with the clinical manifestations of the various groups of reactions, and suggestions are made designed to lower the incidence of their occurrence.

References

1. Barker, M. H.; Lindberg, H. A., and Thomas, M. E.: Sudden death and mercurial diuretics. J.A.M.A., 119:1001-1004, (July 25) 1942.
2. Batterman, R. C.; DeGraff, A. C., and McCormack, J. E.: Effectiveness and safety of mercupurin administered orally in treatment of congestive heart failure. J.A.M.A., 124:1243-1247, (Apr. 29) 1944.
3. Batterman, R. C.; DeGraff, A. C., and Shorr, H. M.: Further observations on use of mercupurin administered orally. Am. Heart J., 31:431-437, (April) 1946.
4. Ben-Asher, S.: Fatal reaction following intravenous injection of mercupurin. J.M. Soc. New Jersey, 42:174-178, (June) 1945.
5. Blumgart, H. L.; Gilligan, D. R.; Levy, R. C., and Brown, M. G.: Action of diuretic drugs. 1. Action of diuretics in normal persons. Arch. Int. Med., 54:40-81, (July) 1934.
6. Borg, J. F.: Treatment of edema with an orally administered diuretic. Am. Heart J., 24:397-404, (Sept.) 1942.
7. Boyer, N. H.: Aminophylline and related xanthine derivatives. J.A.M.A., 122:306-309, (May 29) 1943.
8. Bridges, W. C.; Wheeler, E. O., and White, P. D.: Low sodium diet and free fluid intake in treatment of congestive heart failure. New England J. Med., 234:573-578, (May 2) 1946.
9. Burrows, A., and Stokes, W.: Mercurial diuretics: intolerance as shown by skin sensitivity. Brit. Heart J., 7:161-167, 1945.
10. Carryer, H. M., and Smith, H. L.: Diuretic efficacy of oral administration of a preparation of mersalyl and theophylline in cases of congestive heart failure. M. Clin. North America, 28:911-914, (July) 1944.
11. Chapman, D. W., and Shaffer, C. F.: The mercurial diuretics: a comparison of acute cardiac toxicity in animals and the effect of ascorbic acid on detoxification in their intravenous administration. (Read before the nineteenth meeting of Central Society for Clinical Research in Chicago, Illinois, Nov. 1-2, 1946.)
12. Clark, T. W.: Diet and diuretics in the treatment of Congestive heart failure. Clin. North America, 1286-1299, (Nov.) 1946.
13. Dechard, G. M.; Calvin, D. B., and Herrmann, G. R.: Blood plasma volume and serum protein studies during diuresis. Texas Rep. Biol. & Med., 2:47-60, 1944.
14. DeGraff, A. C., and Lehman, R. A.: Acute Toxicity of mercurial diuretics. J.A.M.A., 119:998-1001, (July 25) 1942.
15. DeGraff, A. C., and Nadler, J. E.: Review of toxic manifestations of mercurial diuretics in man. J.A.M.A., 119:1006-1011, (July 25) 1942.
16. Finkelstein, M. B., and Smyth, C. J.: A comparative study of mercuhydrin and mercupurin, oral and parenteral. J. Michigan State M. Soc., 45:1618-1624, (Dec.) 1946.
17. Horine, E. F.: Clinical experiences with mercurial diuretics in prevention of acute paroxysmal dyspnea. South. M. J., 33:315-318, (March) 1940.
18. Leaman, W. G.: The Treatment of congestive cardiac failure with special reference to the prolonged use of mercurial diuretics. Clinics, 5:3-17, (June) 1946.
19. Leevy, C. M.; Strazza, J. A., and Jaffin, J. A.: Fluids in congestive heart failure. J.A.M.A., 131:1120-1125, (Aug. 3) 1946.
20. Marshall, F. A.: Tetany following mercurial diuresis. J.A.M.A., 133:1007-1008, (April 5) 1947.
21. Modell, W.: Optimal dose of mercurial diuretics. Ann. Int. Med., 20:265-274, (Feb.) 1944.
22. Murphy, Alex.: Sudden deaths following initial injection of mercurial diuretic. M. J. Australia, 1:589-590, (April 27), 1946.
23. Nicholson, W. M., and Moseley, V. E.: Use of erythrol tetranitrate as a diuretic. South. M. J., 34:331-336, (March) 1941.
24. Page, S. U.: Indications for drug therapy in heart disease. Canad. M. J., 49:195-200, (Sept.) 1943.

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Michigan Wants Excellent Nursing -- Two Kinds

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ABOUT the same time as the Michigan Hospital survey was being made the nurses of the state determined to learn the status of nursing in Michigan.[1] This was with the view of accepting the facts and doing something about the recommendations that would follow.

It was already understood that the greatest cause for the difficulties experienced by civilian hospitals was the new demand for nurses to meet, especially, the postwar needs of governmental and civilian hospitals.

It was soon realized that not only was the assistance of the medical and allied professions needed but that nurses must organize as one agency to pull together for nursing as a whole and not dissipate effort at such an important moment because of specialized interests.

The result is the Michigan Nursing Center Association, 750 East Main Street, Lansing, incorporated August 28 as the successor to the Michigan Council on Community Nursing.

Here one staff will serve all nursing interests, working under a general board that represents all interests. Its Advisory Committee includes not only representatives of the medical and hospital associations, but also of other professions, and important lay members who can help nursing at this strategic time.

The program to help the hospitals is being promoted in several ways. First, and because it represents nursing officially, the State Board of Nurse Registration assists by extending the granting of permits to hundreds of graduate nurses not eligible for registration because their schools permitted standards lower than those of Michigan. These nurses can work safely in local hospitals under supervision.

Examinations for students are still given just as frequently as during the war and in as many places.

The Board is assisting schools in strengthening their teaching, in encouraging the centralization of

Article written for the Michigan Nursing Center Association, by Miss Ross, chairman of the Committee on Practical Nursing.

at least the basic sciences, and in promoting affiliations especially in the mental hospitals. The nurses need this fine experience and the mental hospitals very much need more nursing care, graduate and student, for their patients. It is gratifying that three state institutions are now offering an excellent student program, and that additional students are sent to them as quickly as facilities permit.

The Michigan Nursing Center Association is busy with many programs. Of special interest here is the promotion of courses, on and off campus, for strengthening nursing school faculties—in nursing arts, in specializations, and in the health and social factors incident to good patient care and patient rehabilitation. This has been made possible by the generosity of the W. K. Kellogg Foundation.

With State Board support, it is promoting the inclusion of rural nursing as an affiliation in the basic course, utilizing increasingly those rural hospitals that can offer experience of educational value to rotating students.

The philosophy of Michigan nurses is not that the increasing demand for nurses be met by great numbers of inadequately prepared graduate nurses, but that the duties in nursing care and service shall be allocated to only two kinds of nurses, the professional and the practical.

The professional nurse is still required to have three years of schooling and the practical nurse one year of schooling.

The professional nurse shall be prepared to function in all nursing duties but because a sufficient number of graduates to carry the total nursing load of the future is now known to be impossible, and because of hospital economic factors, her duties can be largely those necessitating greater knowledge and technical skill.

The preparation of the practical nurse is geared to meet her function as defined by the Office of Education, Washington, D. C., after approval by all the National Nurse organizations:

"A practical nurse is a person trained to care for subacute, convalescent, and chronic patients requiring nursing services at home or in institutions, who works under the direction of a licensed physician or a registered professional nurse, and who is prepared to give household assistance when necessary. A practical nurse may be employed by physicians, hospitals, custodial homes, public health agencies, industries, or by the lay public.

"The definition suggests specific controls and limitations of practical nurse activities, establishes relationships with the physician and the professional nurse, implies that patient care comes first and that care of the home is justified only to the extent that it is necessary to insure patient peace of mind and desirable home conditions."[2]

The Michigan Nursing Center Association has aimed to provide hospitals with the most adequate service in the shortest possible time. This can be accomplished by establishing one-year schools of practical nursing in six centers throughout the state. The plan has been worked out jointly with the State Department of Education through its Board of Control of Vocational Education and with the National Association for Practical Nurse Education. It has been approved, and its deficit of over $45,000 annually has been underwritten for three years by the W. K. Kellogg Foundation. An additional gift of over $14,000 has also made possible at Wayne University a summer course for the preparation of the personnel for the project.

The centers already offering evidence of financial aid and favorable public backing sufficient to start fall classes are Flint, Traverse City, Marquette, Battle Creek, Lansing and Detroit.

The plan will have as its head an over-all coordinator in the office of the State Board of Control, and in each center school will be a co-ordinator, supported by a local lay advisory committee, a nurse teacher, a home economics teacher and a clerk.

The class teaching for four months will be done preferably in the public school, and the practical experience for eight months obtained in local health and social agencies and in mental, tuberculosis, convalescent, rural or in general hospitals conducting schools of professional nursing if there is more clinical material available than needed for that purpose.

Agencies will pay for student services on a per diem basis.

Professional and practical nurses will function most efficiently and economically in the hospital when working in teams differing in number according to the needs of patients in the particular hospital units served. The ratios of graduate nurse to practical nurses will be only one of the several problems to be worked out by the Research Committee.

The graduate nurse is made responsible for the welfare of the patients, and she allocates to the practical nurses the kinds of duties at the appropriate times which they are prepared to do.

Because space does not permit details, they can be found in "Nursing XYZ" in the August issue of *Hospitals*. The article is written by Lucille Petry, Chief, Division of Nursing, U. S. Public Health Service. More details are given in a follow-up editorial, "Nursing Y Training Funds."

The medical profession and the hospitals can promote this development to a great extent by recognizing the practical nurse as an important part of the nursing service. Respecting her for the work she can do is as important as refraining from requesting her to do or expecting her to do those duties for which she has not had preparation.

That all Michigan hospitals and physicians understand and respect the abilities and limitations of the practical nurse is most essential to the success of this venture. The public can be informed very quickly also if the physicians are willing to make matters clear to them.

Legislation to protect the practical nurse and the status of practical nursing will be fostered soon, and everything we can do now to make it clear that the physician, the professional nurse and the practical nurse each has a place in the medical field, each supporting the other, will make the establishment of the new helpful law that much easier.

It is good to remember that such a law does not affect any who are working as practical nurses now, because all would be blanketed in under a waiver. Practical nurses of the future, however, would have to go to school to prepare, just as professional nurses and physicians must now do.

The Michigan Nursing Center Association will promote recruitment for the field of nursing in all areas, for professional and for practical nurses at the same time. Preference and preparation will determine which nursing course to follow.

It will be of interest to know that the Detroit Board of Education offered the Goldberg Vocational School to the Practical Nursing School of Detroit, and the latter moved in September 1, in time for fall classes. The program calls for a new class of twenty every eight weeks. Facilities are being enlarged as needed up to a capacity of 500 yearly.

The other centers have made plans for three classes during the year of twenty students each.

The Michigan Nursing Center Association, in its effort to provide better nursing care to greater

(Continued on Page 1406)

Parathyroid Extract and Diuresis

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R. C. Moehlig

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PARATHYROID EXTRACT produces diuresis, and this pharmaceutical effect of the extract is useful in certain conditions. In the oliguria and anuria of nephritis we have found it to produce marked diuresis. This diuretic effect of parathyroid extract has been known for some time. We have also used it in edema resulting from allergy.

One of our patients was in a desperate condition due to injury of the kidneys from sulfadiazine therapy. It is in this condition that parathyroid extract may prove of great benefit in the treatment of oliguria or anuria resulting from overdosage or sensitivity to this group of drugs. The universal popularity of the sulfonamides, due to their efficacy, has resulted in occasional cases of uremia as a result of overdosage or sensitivity to the drugs. For this reason we are prompted to emphasize the beneficial effects of parathyroid extract.

Illustrative of the effect of parathyroid extract on diuresis and edema are the following two cases.

Case Reports

Case 1.—Mr. R. L. (No. 287147), a fifty-nine-year-old white man, entered Harper Hospital on April 12, 1944, with main complaints of sporadic nausea and vomiting over the previous five days, and with a history of oliguria during the last seventy-two hours prior to admission. His condition apparently was secondary to the administration, on the fourteenth day prior to admission, of sulfadiazene and soda bicarbonate in equal amounts of 1 gram every four hours for twelve doses to alleviate

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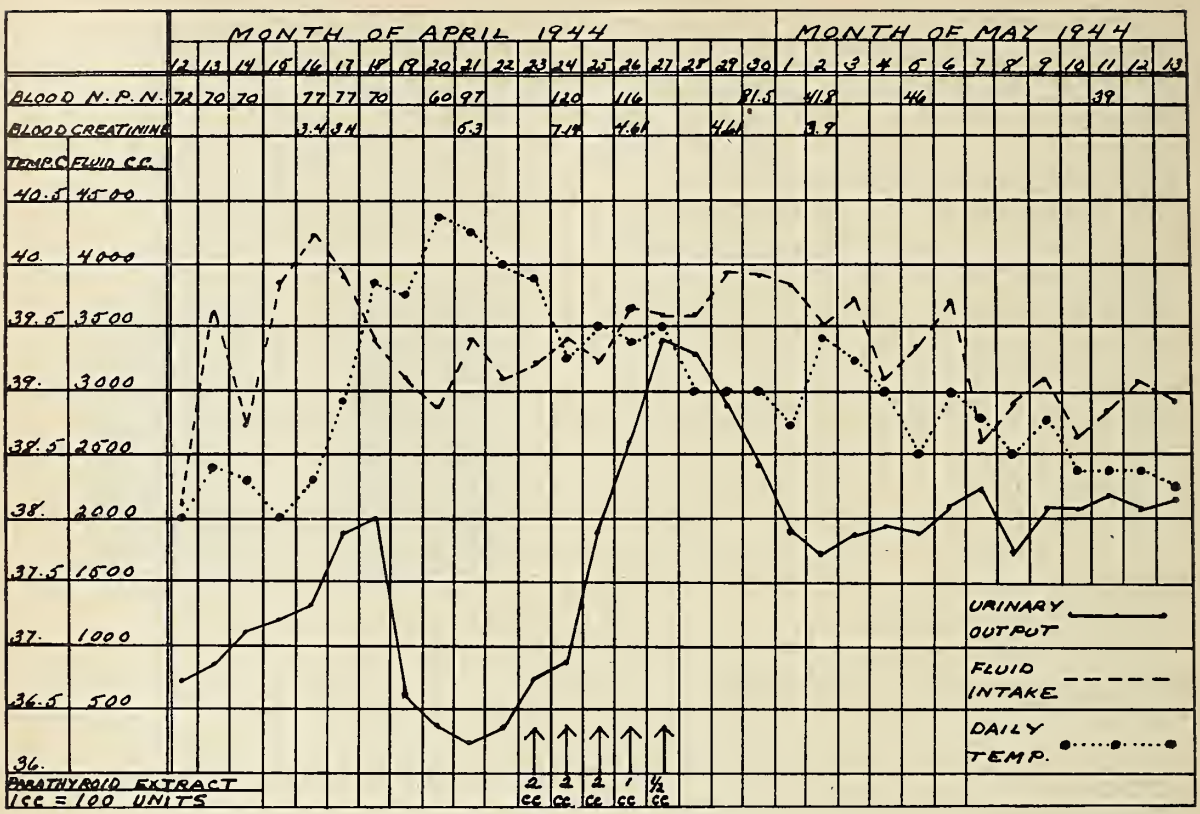

Fig. 1. Record of Case 1, Mr. R. L.

an acute bilateral tonsillitis. With the return of a sore throat six days prior to admission, he again was placed on the same drug and dosage regime, which was discontinued after eleven doses because of the onset of anorexia and nausea. The oliguria first appeared twenty-four hours later, on April 9, continuing up to the date of admission. The fluid intake over the past week had been sufficient.

His past history was essentially negative except for a severe attack of quinsy sore throat twenty years previous. He had had no former genito-urinary symptoms.

Physical examination showed that the patient was a well-nourished, elderly white man with a warm dry skin, a temperature of 37.5° Centigrade orally, a dry coated tongue, and a slight tenderness to palpation over the right flank of the abdomen. He weighed 170 pounds (77.4 kg.) and was 66 inches (167.6 cm.) in height. His blood pressure was 130/80, pulse 92, and respiration 18 per minute. The remainder of the physical examination was essentially normal including the rectal and neurological examinations.

A diagnosis of oliguria, secondary to the administration of sulfadiazine, was made after the admission examination.

The routine laboratory findings on admission (Fig. 1) were: erythrocyte count of 5,020,000, hemoglobin of 13 gm. by the Sahli method, a leukocyte count of 19,950 with a normal differential count. The urine was amber in color, acid reaction, specific gravity 1.008, with 1-plus albumen, and the microscopic study showed the urine loaded with erythrocytes and sulfadiazene crystals. The admission blood chemistry revealed a negative Kahn test, a nonprotein nitrogen level of 72 mg. and a sulfadiazine level of 5.95 mg.

The patient was cystoscoped on the afternoon of admission, at which time both ureters were found to be blocked with sulfadiazine crystals. The ureters were catheterized and irrigated with great difficulty. The catheters were then left in place and the patient was given 1,000 c.c. of 10 per cent glucose in distilled water intravenously twice daily, along with fluids freely by the oral route. After forty-eight hours the intravenous fluid was changed to 1,000 c.c. of a 5 per cent solution of glucose in distilled water given twice daily.

The patient responded satisfactorily until April 18, the seventh hospital day, when his urinary output was again greatly reduced and associated with abdominal distension, mild diarrhea, nausea and anorexia, and a rise in temperature to 39.8° Centigrade orally. At this time the blood chemistry showed a level creatinine to be 3.4 mg. and the nonprotein nitrogen to be 77 mg. The patient became edematous. A Levine tube was inserted into the stomach to aid reduction of the distressing abdominal distension. Oxygen was administered by an oxygen tent. Intravenous fluids were maintained above 3,000 c.c. per day (Fig. 1). Two days later (April 20), with decreasing urinary output, the blood carbon-dioxide combining power was 36 per cent and the blood non-

protein nitrogen showed a level of 60 mg. On the next day the blood creatinine level was 5.3 mg. and the nonprotein nitrogen had increased to a level of 97 mg. The patient was rapidly failing in a typical picture of terminal uremia, and all hope for recovery was abandoned since blood transfusions, hypertonic glucose solutions intravenously, and the usual procedures failed to produce the necessary diuresis.

On April 23 we injected intramuscularly 2 c.c. (200 units) of parathyroid extract. This drug in the same amount was repeated on the following day, at which time the blood creatinine level was 7.4 mg. and the nonprotein nitrogen was 120 mg. Late in the afternoon of April 24 the patient began to pass increasing amounts of urine. Two c.c. of parathyroid extract were again given on April 25 and 26. On the latter date the blood creatinine was 4.61 mg. and the nonprotein-nitrogen 116 mg. with a urinary output of 2,600 c.c. On April 27 1 c.c. of parathyroid extract was given, and ½ c.c. on the following day. The drug was then discontinued because of the striking clinical improvement following the marked diuresis, as shown in Figure 1.

The patient continued to show marked improvement, and on May 24 another retrograde pyelogram revealed a nonfunctioning right kidney. The patient was discharged much improved on June 2, 1944. After a six weeks' rest at home he returned to work and has been working daily since that time.

In October, 1946, the patient had a re-check intravenous pyelogram which revealed the same finding, a nonfunctioning right kidney. He was asymptomatic and the physical examination was essentially normal.

Case 2.—Mrs. K. L. (No. 349234), a thirty-six-year-old white woman, entered the hospital on December 28, 1946, with the complaint of generalized urticaria, edema, and sporadic convulsions, attributed to the ingestion orally of four tablets (25,000 units each) of penicillin on December 16. She had been ill at home for approximately three days prior to admission. She had been given benadryl, 50 mg., four times a day with no resulting benefit.

Her past history was essentially negative. She had taken the penicillin tablets for acute conjunctivitis twelve days prior to admission. There was no familial history of allergy.

Physical examination revealed an extremely edematous and uncomfortable white woman. The skin showed numerous giant urticarial lesions associated with soft tissue edema. The blood pressure on admission was 90/50, pulse 112, and temperature 37° Centigrade orally. She weighed 120 pounds (54.5 kg.) and was 63 inches (160 cm.) in height. The remainder of the examination was normal.

The laboratory examination of the urine, including microscopic study, was normal. The examination of the blood was as follows: hemoglobin 10.8 gm. (Sahli), erythrocytes 3,780,000, leukocytes 16,300, with a differential of 28 stabcells, 44 segmented cells, 22 small lymphocytes, 2 large lymphocytes, one monocyte, and 3 eosinophils. The blood Kahn test was negative. The fasting blood sugar was 100 mg., nonprotein nitrogen 27.5 mg., total serum protein 5.4 mg., albumin, 3.4 mg. and globulin of 2.08 mg.—the albumin-globulin ratio 1.6:1. The roentgen studies of the skull were normal.

The patient on admission was given 10 minims of 1:1000 solution of adrenalin subcutaneously, with some

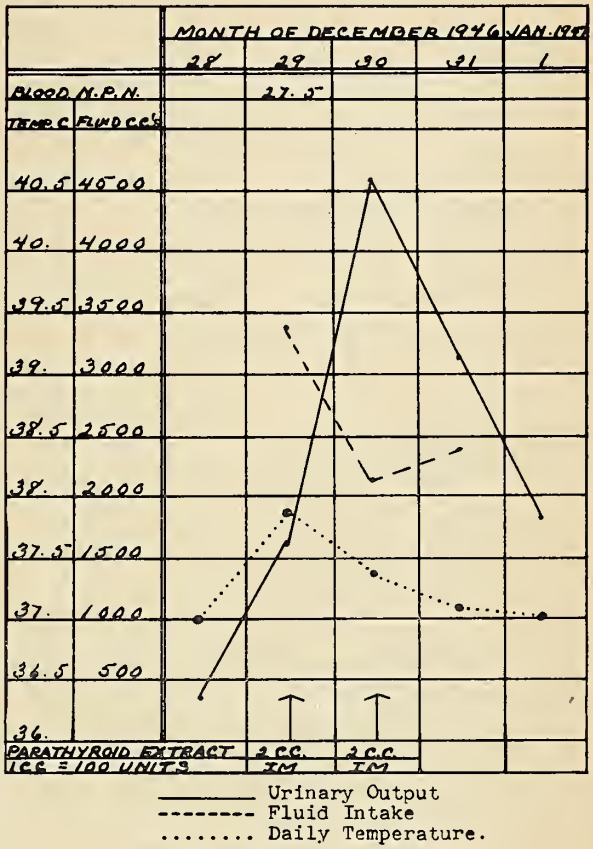

Fig. 2. Record of Case 2, Mrs. K. L.

diminution of the edema. However, during the afternoon on the day of admission the patient was again given 50 mg. of benadryl orally, only to have a sudden exacerbation of her symptoms starting approximately three hours after ingesting the benadryl. This drug was immediately discontinued.

The next morning, December 29, the patient's edema had increased greatly so that her eyes were completely closed; her legs showed a 4-plus pitting edema; she was irrational. The patient was not urinating despite adequate intake.

Since giving 10 minims of 1:1,000 solution of adrenalin subcutaneously every three hours, and since hypertonic 50 per cent glucose solution intravenously appeared to have no effect on the severe edema, she was given at noon of December 29, 2 c.c. of parathyroid extract intramuscularly. The dose was repeated on the following morning with resulting profuse output of urine (Fig. 2) and rapid disappearance of the generalized edema two days later.

The patient was discharged from the hospital on January 4, 1947, free from edema and other symptoms.

Comment

The first patient was desperately ill and the family had been given a hopeless prognosis by the family physician, the consultant internist, and the urologist. Because we knew that parathyroid extract

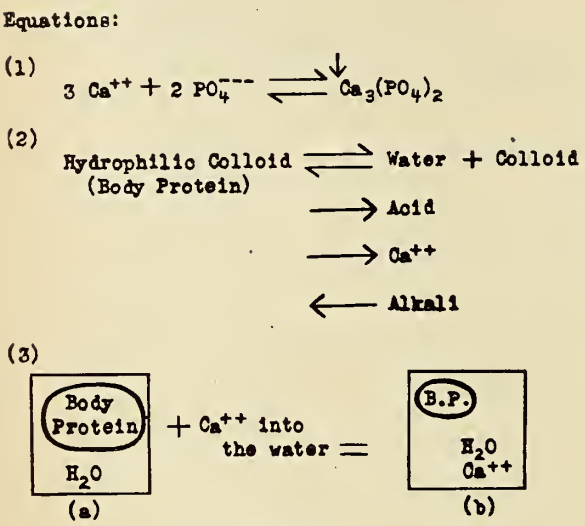

Fig. 3.

produced diuresis we employed it in the first patient with excellent results. In the second patient the extract produced a marked diuresis with rapid disappearance of the edema. This disappearance of the edema, associated with the marked diuresis, was dramatic. It is therefore worthwhile to revive interest in this extract for these therapeutic purposes, particularly, as we said previously, since the sulfonamides are being used so extensively.

The diuretic effect of the parathyroid extract is directly proportional to the degree calcium is mobilized in the blood. The three equations in Figure 3 help to explain this fact.

Equation (1) illustrates the joining together of the calcium ions with the phosphate ions to form the precipitate calcium phosphate. This reaction is taking place continually between the calcium and phosphate ions in the blood serum and the precipitated calcium phosphate within the skeletal system. If the media in which the reaction is taking place is made acid, the resulting reaction is toward the left; and, conversely, if made alkaline, the shift is toward the right. If the free phosphate ions are reduced in the blood, there is an immediate shift of the reaction to the left, causing a demobilization of calcium from the bony reservoirs and resulting in a temporary increase in serum calcium. In Equation (2) is shown body protein (tissue) saturated with water, hydrophilic colloid, being easily broken down into water and colloid by the addition of calcium ions or an acid, and likewise a reversal taking place when the media is made alkaline. Equation (3) illustrates a simple experiment which can be performed as follows: In a beaker of water place an edematous piece of body protein. To the water then add calcium ions, with a resulting dehydrating effect upon the body protein which can be observed grossly.

The exact site of the action of the parathyroid extract is still a debatable question. Sevringhaus[14] stated, "The exact chemical and physiological mechanisms involved in the control of minerals by the parathyroids are not known. One of the simplest ways to view the parathyroid function is to consider the primary activity of the hormone as facilitating excretion of inorganic phosphorus by the kidneys. Overfunction will lead to depletion of serum phosphorus, with resultant mobilization of this element from the bony reservoirs. Necessarily, this will involve mobilization of calcium, and thus the low serum phosphorus and high serum calcium are explained. Conversely, reduced hormone function will be followed by accumulation of serum phosphorus and consequently tendency of phosphorus to enter the bony reservoirs, in which case calcium must also enter. In this process there will be elevated serum phosphorus and depressed serum calcium. In the first case bones will become decalcified, in the latter case, abnormally densely calcified."

As late as 1942 some writers[1,2,3,8] defended the theory that the primary point of attack of the parathyroid hormone is on the kidney since the first result of the administration of parathyroid extract detected was a lowering of the renal threshold for phosphorus accompanied by an increased elimination of phosphate and a decrease in the organic phosphorus content of the serum. Selye[13] reported the results on a series of forty-eight rats in an attempt to show that parathyroid hormone produces osteitis fibrosa even in the nephrectomized animal. His conclusions were that his experiments on the rat indicate that complete nephrectomy does not prevent the action of the parathyroid hormone on bones. Nephrectomy itself elicits bone changes similar to those caused by the parathyroid hormone, though they are comparatively mild and develop more slowly. Parathyroidectomy prevents

the bone changes caused by nephrectomy. Hence, he concluded that the hormone of the parathyroid does not act on the bones through the intermediary kidney, as had been postulated by others. Nephrectomy, on the other hand, probably affects the bones because it stimulates the production of this hormone by the parathyroids.

Collip's work on dogs,[7] in which hypercalcemia was produced by resulting overdosage of parathyroid extract, showed that the clinical manifestations of hypercalcemia in dogs appear to be loss of appetite, dullness, drowsiness verging into coma, general atonia, and a failing circulation; also that the animals are always obviously dehydrated, the blood becomes very concentrated, and it becomes a matter of great difficulty to secure serum from blood samples for analysis even when a high-power centrifuge is used. He also noted that immediately after death the blood in the heart and the great vessels formed a firm clot.

Brougher[5] reviewed 1,000 cases of pregnancies, of which eighty-eight cases of eclampsia were the basis for his paper. He gave 1 c.c. of parathyroid extract intramuscularly once daily for four days. He noted that in every case the extract produced a marked diuresis, lowered the blood pressure, lessened ankle edema and promoted weight loss. He stated that parathyroid extract was found to be of value in reducing edema and relieving the symptoms of pre-eclamptic toxemia. He felt that it was a useful drug in early cases of pre-eclamptic toxemia and should be tried in a larger series.

Cantrarow[6] states that, "Whatever may be the exact nature of the mechanism involved, there can be no doubt of the effectiveness of calcium therapy in producing diuresis and diminution in edema in cases refractory to other types of therapy. Calcium and parathyroid therapy has, therefore, been observed to cause diuresis in acute and chronic nephritis, nephrosis, cardiac failure, diabetic edema, hydrothorax, and ascites."

Rockwood and Barrier[12] obtained good results in diabetic edema and in chronic glomerulonephritis by the oral administration of 12 to 18 gm. of calcium lactate daily. In some of their cases the use of calcium chloride was attended by success after calcium lactate had failed. They noted that renal function was distinctly improved and no ill effects were noted.

McCann[11] in 1928 reported the effect of the injection of 20 to 40 units of parathormone at intervals of two or more days upon the fluid and salt elimination in three patients with acute and chronic nephritis with generalized edema. In each case he reported, diuresis occurred, lasting for several days after a transient increase in serum calcium concentration.

The one possible contraindication for the use of parathyroid extract is the patient who is digitalized. It is now a well-known fact[4] that calcium in excess in the serum acts on the heart muscle to increase contractility, which in turn increases the duration of systole at the expense of diastole. This action is a direct antagonist to potassium.

The cardiac action of calcium[9] in some ways resembles that of digitalis. It has been reported that high concentrations of calcium in the circulation increase the toxicity of digitalis. However, clinically we have observed no toxic effect. We believe that the margin of safety is great. Hoff and his associates[10] reported their experimental work with dogs in which they injected calcium chloride intravenously while noting the electrocardiographic changes taking place. They noted that when the calcium serum level reached 29 mg. per cent, a bradycardia, probably of vagal origin, and T wave changes occurred. Death occurred either from ventricular fibrillation at an average calcium level of 60 mg. per cent or from cardiac slowing with gradual arrest at higher calcium levels.

Summary

We have called attention to the use of parathyroid extract in a case of oliguria with uremia due to sulfadiazine and a case of edema due to allergy. Charts showing the diuretic effect of parathyroid extract are presented. The explanation of the extract's diuretic effect is outlined. The dramatic effect was so marked that our enthusiasm prompted us to re-emphasize this pharmacological action of parathyroid extract.

References

1. Albright, F.: The parathyroids—physiology and therapeutics. J.A.M.A., 117:527, 1941.
2. Albright, F., and Ellsworth, R.: Studies on the physiology of the parathyroid glands. 1. Calcium and phosphorus studies on a case of idiopathic hypoparathyroidism. J. Clin. Investigation, 7:183, 1929.
3. Anderson, W. A. D.: Hyperparathyroidism and renal disease. Arch. Path., 27:753, 1939.
4. Best, C. H., and Taylor, N. B.: Physiological Basis of Medical Practice. Third ed., p. 266. Baltimore: Williams & Wilkins, 1943.
5. Brougher, J. C.: Parathyroid extract in pre-eclamptic toxemia. Am. J. Obst. & Gynec., 43:710-714, 1942.
6. Cantarow, A.: Calcium Metabolism and Calcium Therapy. Second ed., p. 198. Philadelphia: Lea & Febiger, 1933.

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Control of Blood Loss During Delivery

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BLOOD LOSS during delivery is unquestionably the most constant problem with which the obstetrician, casual and specialist, is confronted. Not only is there the danger of fatal postpartum hemorrhage, but the blood lost by the so-called "normal" parturient woman is too often undesirably extensive. The principal effects of this excessive blood loss, namely, delayed convalescence and lowered resistence to infection, are well known and need only be mentioned. But what is most unfortunate is the attitude of nonchalance toward this blood loss on the part of the obstetrician. As long as bleeding stops before there has been actual postpartum hemorrhage, he is satisfied. Rather than this, his attitude should be that *any* blood loss is undesirable, and he should direct every effort toward achieving the goal of "blood loss—none."

Another group of patients also deserves consideration, those who suffer postpartum hemorrhage. During the last half of 1946 there were in this hospital ten cases with a blood loss greater than 500 c.c., an incidence of 1.4 per cent. It will probably never be possible entirely to eliminate such an occurrence, but we can try.

Since the blood loss with which we are concerned occurs during the third and fourth stages* of labor, it is apparent that the management of these stages is the key to the problem. Various oxytocic substances have been used, and these in various ways. The fact that no single method of handling these stages of labor has been universally adopted is good evidence that the solution has not yet been found. Much has been written concerning the pathologic factors contributing to blood loss, but little attention has been given the "normal" mechanism. It is with the latter subject that this paper will be principally concerned.

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*The fourth stage of labor is defined as the first hour following delivery of the placenta.

During delivery there are several factors involved in the blood loss. These may, in general, be divided into two groups, the first physiological, the second traumatic. Physiological blood loss will include the retroplacental blood clot and bleeding from the placental site after separation. Traumatic factors include lacerations of the perineum, vagina, cervix, and, fortunately rarely, the uterus itself. These traumata are fairly well understood, and their treatment is more or less definitive. It is the physiological blood loss which is unpredictable, which, when excessive, becomes pathological, and which, in any event, is undesirable.

For purposes of discussion we may define the "normal mechanism" as that chain of events which occurs during labor resulting in a total blood loss of 50 c.c. or less. What constitutes this mechanism? The placenta is attached to the uterine wall by the decidua basalis. The placental villi lie in pools of maternal blood which have an open circulation—that is, there is no continuity between the arterioles and venules which supply them. The uterus itself is distended by the fetus. Separation of the placenta occurs when this distension is reduced by contraction of the uterine musculature, causing the decidua basalis to dissect from the uterine wall. This process usually occurs with the formation of a retroplacental blood clot; and physiologically this clot will constitute the only blood loss, for, as the uterus is emptied, the contracting musculature will reduce the size of the maternal blood sinuses and permit completion of the thrombotic process already begun. The small amount of bleeding which does follow forms a clot in the uterus which is retained throughout the fourth stage.

There are, therefore, two questions to be answered. First, what causes this normal mechanism to fail, thus permitting a pathological blood loss. And second, knowing these things, what can we do to prevent this failure?

The uterus is a hollow viscus, the wall of which is composed of smooth muscle fibers which, at term, are greatly hypertrophied and stretched. As the contents are evacuated, the fibers become contracted, a process which requires readjustment of tone at their new length and which requires time. No one would think of evacuating a greatly distended bladder in a few seconds. Why, then, so abuse the uterus? When sufficient time is not allowed for this readjustment, the normal mechanism is interrupted and bleeding occurs. Other fac-

tors may also interfere with this adaptation of the myometrium, particularly uterine inertia. A greatly distended uterus, as in multiple pregnancy, hydramnios, or even with an excessively large single fetus, will adapt more slowly and hence requires careful attention. Also, a patient who is to be delivered in the presence of secondary inertia requires special attention since the inertia will be carried over into the third and fourth stages of labor. Multiparas with often repeated pregnancies and the "grande multipara" are prone to exhibit atony. Fibromyomata may interfere with adequate contractions.

Of special importance is the delivery of the placenta. This organ usually separates with the first contraction of the uterus following delivery of the fetus. As soon as it has separated it should be delivered. As pointed out above, the maternal sinuses begin to thrombose as soon as separation has occurred, and this process is aided by the contracting myometrium. A separated placenta retained in the uterus prevents full contraction of the muscle fibers. Blood loss may not be evident at the time, but when the placenta is finally expressed, the thrombotic process must begin anew, and this increases blood loss.

There is another reason why the placenta should be expressed promptly. The first strong contraction of the uterus involves principally the fibers of the corpus. Then there is a brief but definite relaxation of these fibers which is most marked at the junction of the upper and lower uterine segments. Succeeding this relaxation there is a strong and prolonged contraction, now most marked at this junction, and this continues to form the physiologic contraction ring at that site. If the placenta is not delivered before this contraction ring forms, it may be retained many minutes—which, potentially at least, increases blood loss.

Lastly, the blood clot remaining in the uterus is sometimes expressed by over-zealous assistants or nurses. This factor has been discussed by Greenberg,[2] who states that this is responsible for much of the blood loss during the fourth stage of labor, and, when carried to extremes, may be exsanguinating.

It is seen from the foregoing discussion that the normal mechanism is vulnerable in all three phases, namely, the initial adaptive mechanism, the delivery of the placenta, and the fourth stage of labor. The management of the last of these phases has been discussed at length by Greenberg,[2] and let it suffice to state here only that the clot remaining in the uterus during this stage should not be expressed.

As previously discussed, the adaptive mechanism is that phase of delivery during which the uterus contracts with consequent shortening of the fibers of the myometrium. Two drugs have been used extensively to aid this process, namely, pitocin and ergotrate. These substances have been used in various ways, both alone and in combination. Let us consider briefly the pharmacology of these agents.

Pitocin is the purified oxytocic principle of posterior pituitary extract. It is assayed to contain 10 international units per c.c. of oxytocic substance and less than 0.5 units per c.c. of pressor substance. The oxytocic substance exerts a profound effect on the uterus causing a strong contraction. This contraction begins 30 to 40 seconds after the intravenous administration of the drug and is maintained for 60 to 90 seconds. The uterus then relaxes slightly and contracts again. The second contraction, in the absence of other factors, is followed by relaxation; the complete contractible phase lasts about 2½ minutes. Pitocin affects both the upper and lower uterine segments—the latter, however, to a considerably lesser degree. When this drug is administred near the end of the second stage of labor, the strong uterine contraction will have two principal effects: first, the extraction of the fetus will be facilitated, and, second, the separation of the placenta will be accelerated. The two contractions mentioned above occur, but these are followed not by complete relaxation but by a continuation of the second contraction with the formation of a very firm physiologic contraction ring at the junction of the upper and lower uterine segments which usually reduces the opening into the fundus to about three centimeters. This contraction ring is slow to relax, but it will do so. The size of the dose of pitocin affects the strength of the contractions, but the duration only slightly.

Ergotrate is obtained from the rye fungus, *Claviceps purpurea.* It is a powerful oxytocic but differs from pitocin in that it causes a tonic, sometimes tetanic, contraction of the uterus. The drug is rapidly absorbed from the gastrointestinal tract, and its effects may be observed ten minutes after oral administration. After intravenous injection the effects begin in about thirty seconds, and after intramuscular use, in about seven minutes.[3] The duration of the contraction is shortest after intra-

venous use and longest after oral use. The duration of the contraction varies roughly with the amount of drug given.

The properties enumerated above may be used to aid the normal mechanism and prevent its failure. It has already been stated that the fetus should be extracted slowly. This is the first step toward minimizing blood loss and, in our experience, the most important. Second, pitocin should be injected intravenously as the biparietal diameter of the head passes the vulvar ring. The dosage will be discussed below, but in general it will be larger if uterine atony is anticipated. The accoucheur should then hold the head, without exerting traction, until the uterus becomes hard, and then he should support the infant while it delivers spontaneously. It is not necessary to wait until the anterior shoulder is delivered before injecting this drug. If shoulder dystocia does occur, the force of the uterine contraction will be very helpful, and with the dosage used there is no danger of rupture of the uterus. Third, the placenta should be expressed as soon as possible after extraction of the fetus. This will be within one or two minutes unless there is failure of separation for one reason or another. In the great majority of cases the placenta will be separated, but one or two attempts at expression will reveal an adherent placenta if it is present. Fourth, ergotrate should be given as soon as the placenta is expressed, preferably by the intramuscular route, since this will produce the desired tonic contraction within the necessary time interval and will give a more sustained effect than will intravenous administration.

The rationale for these procedures is clear. The initial strong contraction produced by pitocin aids the myometrium in adapting to its new length, and the fetus is extracted at the time the adaptation is occurring; thus there is never a discrepancy between the volume of the uterus and the size of its contents. The placenta is expressed quickly so that the physiologic contraction ring will not impede its delivery. Ergotrate aids in maintaining the myometrium in a contracted state. The total effect is minimal blood loss.

With these factors in mind the use of pitocin intravenously was begun in this hospital in October, 1946. It was our clinical impression that blood loss was definitely less when this drug was given at the end of the second stage of labor than it had been when ergotrate was used alone. In an attempt to evaluate our results objectively, a series of 392 cases was reviewed. The analysis of these cases is subject to several criticisms. First, the series is too small to permit statistical analysis. Secondly, the patients were delivered by a large number of different operators, whose differences in technique cannot be evaluated with relation to blood loss. Third, all blood loss determinations were estimated—not measured—and therefore subject to the personal equation. This is partially offset by the fact that all estimations were made by the same two observers, and therefore they are probably comparable.

TABLE I

	Group 1	Group 2	Group 3	Total
a. With Episiotomy	61	100	72	233
b. Without Episiotomy	36	53	42	131
Total	97	153	114	364

The cases were divided into three groups according to the medication the patient received during the third and fourth stages of labor. Group 1 consists of 105 patients who received only ergotrate, 0.2 mg. given intravenously at the end of the second stage. Group 2 includes 166 patients who were given 1.0 unit of pitocin at the end of the second stage and 0.2 mg. of egotrate intramuscularly after expression of the placenta. Group 3 includes 121 patients who received the same medication as those in Group 2 except that the dose of pitocin was 1.5 units.

For purposes of comparison, certain cases were eliminated, and some of these will be considered separately. These were cases of retained placenta, with or without manual removal, true postpartum hemorrhage, cases which required packing of the uterus, and cases in which it was specifically stated in the record that the episiotomy was the principal source of the blood loss. The remaining cases, totaling 364, were subdivided into those with episiotomy, 233, and those without episiotomy, 131 (Table I).

Regardless of the medication, blood loss was found to increase with increase in the length of the third stage of labor. This is consistent with the findings of other authors.[1] These figures are given in Table II. There was no difference in the length of the third stage between the three groups of cases, a finding which was contrary to our impression that this stage was shorter when pitocin was used. The figures for this are summarized in

TABLE II.

Length of Third Stage in Minutes	Average Blood Loss (in c.c.)								
	Group 1		Group 2		Group 3		Average for All Groups		
	a	b	a	b	a	b	a	b	Ave. (a and b)
1	—	—	50	—	—	15	50	15	25
2	175	75	90	40	70	25	90	45	75
3	155	115	80	75	85	45	105	80	95
4	165	90	120	70	90	55	125	70	105
5	270	80	95	75	90	30	140	65	105
6	185	140	110	70	105	75	135	90	115
7	—	150	140	—	25	50	115	70	90
8	100	90	140	75	90	100	115	85	100
9	150	75	90	—	150	—	125	75	115
10	—	—	115	100	100	—	115	100	110
10+	125	75	145	125	95	25	125	90	125

TABLE III.

Length of Third Stage in Minutes	Number of Cases			Per cent		
	Group 1	Group 2	Group 3	Group 1	Group 2	Group 3
1	0	2	4	..	1	3
2	6	23	16	6	14	13
3	28	38	23	27	23	19
4	25	36	32	24	22	26
5	17	23	17	16	14	14
6	10	12	9	9	7	7
7	1	5	5	1	3	4
8	4	5	4	4	3	3
9	3	2	1	3	1	1
10	0	4	1	..	3	1
10+	11	12	9	10	9	9

Table III. Reference to Table II also reveals a decrease in blood loss for any particular length of third stage in those patients who received pitocin, and in general, the larger dose of pitocin was accompanied by a smaller blood loss.

Other variables were considered which might have influenced blood loss. These included age of the patient, method of delivery (spontaneous or operative), type of anesthetic, and parity. In each instance no correlation was found.

Let us consider the abnormal cases in this series. Postpartum hemorrhage occurred eight times. Three of these patients had received ergotrate (3:105 or 2.9 per cent) and five had received 1.0 unit of pitocin (5:166 or 3.0 per cent). No patient who had received 1.5 units of pitocin had a postpartum hemorrhage (0:121). Packing of the uterus should be considered here. There were three such cases and all had received only ergotrate.

Manual removal of the placenta was performed four times. The indication for one of these operations is questionable since it was done three minutes after the delivery of the infant, and the estimated blood loss was 75 c.c. The other three patients had all received 1.0 unit of pitocin. The operation was performed after ten, thirteen, and 107 minutes in these cases, and the blood loss was, respectively, 150, 800, and 600 c.c.

An objection to the use of pitocin has been raised to the effect that its use would sometimes prolong the third stage. With this in mind, all cases in which the third stage was longer than ten minutes were considered separately. There were thirty-four such patients. Of these eleven had received ergotrate (11:105 or 10.5 per cent), fourteen had received 1.0 unit of pitocin (14:166 or 8.4 per cent) and nine had received 1.5 units of pitocin (9:121 or 7.4 per cent). It is evident that pitocin does not cause retention of the placenta.

Aside from averages for the various groups, some facts are worthy of mention, and these are summarized in Table IV. Among patients receiving ergotrate, seven without episiotomy (1 b) had a blood loss between 100 and 200 c.c. and one had a blood loss of 250 c.c.; twenty-nine patients with episiotomy (1 a) lost between 100 and 200 c.c. and twelve lost more than 200 c.c. In the group which received 1.0 unit of pitocin there were six patients without episiotomy (2 b) with a blood loss between 100 and 200 c.c. and one with a blood loss of 250 c.c. In this group and with an episiotomy (2 a) forty-one lost between 100 and 200 c.c. and six patients more than 200 c.c. The third group, patients who received 1.5 units of pitocin, contains no case without episiotomy (3 b)

TABLE IV.

Blood Loss	Group 1				Group 2				Group 3			
	a		b		a		b		a		b	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
100—200	29	27.9	7	6.7	41	25.9	6	3.8	19	16.7	0	....
200—300	9	8.7	1	0.9	5	3.2	1	0.6	1	0.9	0	....
300—500	3	2.9	0	....	1	0.6	0	....	0	....	0	....
Total	41	39.5	8	7.6	47	29.7	7	4.4	20	17.6	0	....

with a blood loss greater than 100 c.c. and only twenty cases with episiotomy (3 a) with this amount of bleeding. These figures indicate quite definitely that *excessive* blood loss occurs less often when pitocin is used and also that the larger dose gives better results.

By way of explanation it should be pointed out that very few of the cases reported in this series were handled according to the principles outlined previously—particularly with reference to slow extraction of the fetus. If they had been followed, blood loss would probably have been much less, because in a series of about fifty consecutive cases not reported here but managed as suggested only two had more than 75 c.c. blood loss.

Conclusions

It will be seen from the foregoing discussion that we can, to a considerable extent at least, control and aid the normal physiological mechanism designed to prevent blood loss. Proper management of the third and fourth stages of labor will then actually begin with proper management of the end of the second stage, that is, with slow extraction of the fetus and the administration of pitocin intravenously. The extraction should be as well controlled as delivery of the head and should require a minimum of 60 seconds since that is the latent period of pitocin. The optimal dose of pitocin cannot be definitely stated, but 1.5 or 2.0 units is usually satisfactory.

Second, the placenta should be expressed immediately, or at least within two minutes after delivery of the infant. It has been shown that the process is easy within that interval but that it becomes increasingly difficult, due to the physiologic contraction ring, as time passes.

Third, ergotrate should be given as soon as the placenta has been expressed. This helps maintain a tonic contraction of the uterus until the total adaptive mechanism of the myometrium has been accomplished.

Fourth, blood clots remaining in the uterus should be allowed to remain. Any stimulation of the uterine musculature should be limited to gentle massage. Pitocin and ergotrate used judiciously are very useful in the treatment of uterine atony and are much more effective than repeated kneading of the corpus uteri.

In conclusion I should like to say that only by continued observation and careful attention to the various factors contributing to blood loss may we finally find the solution to this problem.

Summary

1. The problem of blood loss by the parturient woman is presented.

2. Physiology of the parturient uterus and factors leading to blood loss are discussed.

3. A method of management of the third and fourth stages of labor based on physiologic principles is suggested.

4. The results in this hospital with the use of pitocin intravenously and ergotrate intramuscularly are summarized.

References

1. Fortin, F. F.: A comparative study of posterior pituitary extract administered at the onset of and after the completion of the third stage of labor. Am. J. Obst. & Gynec., 35:761-772, (May) 1938.
2. Greenberg, E. M.: The fourth stage of labor. Am. J. Obst. & Gynec., 52:746, (Nov.) 1946.
3. Jones, J. L., and Barlow, O. W.: A clinical comparison of various ergot preparations on the postpartum human uterus. Am. J. Obst. & Gynec., 29:489-502, (April) 1935.

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NURSING—TWO KINDS

(Continued from Page 1397)

numbers of patients, solicits the help of all and will gladly welcome all constructive criticism that will promote the desired end.

References

1. Bixler, Genevieve Knight: Nursing Resources and Needs in Michigan.
2. Federal Security Agency, Office of Education, Washington, D. C.: Practical Nursing, An Analysis of the Occupation. Price 55 cents.

Treatment of the Common Respiratory Infections

By Harold V. Dwyer, M.D.
Detroit, Michigan

THE ECONOMIC LOSS to individuals and business from time lost due to upper respiratory infections is tremendous. These infections range from the common head cold through various bacterial infections of the nose, sinuses, middle ears, pharynx, larynx, trachae, bronchi and lungs. The infections may be primary in any one or combination of two or more of the above locations, or may be the result of a secondary invasion of the area by bacteria which attack an area attenuated by some previous agent such as a virus, allergen, or physical agent. Many of them result in chronic conditions which plague the individual for years.

The primary stage of the ordinary head cold is probably due to a virus as yet not identified. This stage usually lasts for three or four days, and is characterized by a profuse watery discharge, swelling and engorgement of the mucus membranes, and general discomfort of the individual. It usually clears up at the end of that time if no secondary infection occurs. When the latter does occur, it is characterized by thickening of the secretion, which now becomes muco-purulent or purulent, and symptoms of toxic absorption. It may remain localized in the nose or spread to the adjacent structures. The duration of the secondary stage may be anywhere from ten days to three or four weeks, and may eventually require some type of surgical intervention to provide drainage of pus or removal of diseased tissue. If the acute head cold was limited to the virus stage in all people afflicted, the problem of treatment would be simple. There are, however, hundreds of thousands of individuals whose resistance to infection is low, who never escape the chain of complications brought about by secondary bacterial invasion. Their complaint is frequent and prolonged or continuous colds with extensions to the different parts of the respiratory system, which render them unfit for work for weeks or months during the year.

During the past few years, a method has been developed for the treatment of chronic respiratory infections which is applicable to these cold-susceptible and low-immunity individuals. The method consists of the administration of medicaments by the aerosol or inhalation route. The value of this type of administration has been adequately proven by Barach,[2] Siegel,[7] Vermeleye,[9] Hinshaw,[4] and others. The virtue of the method rests in the fact that the medicines used come into direct contact with the tissues involved, while at the same time a desired blood concentration may be attained. When applied to this group of people, it has been proven to reduce the incidence of secondary infection to a small fraction of its former occurence as well as causing a marked shortening of the course of these infections. This has resulted in an increase in the patients' incomes and large savings to their employers. The usual medication given is penicillin, though streptomycin may be combined with it or given alternately. Penicillin in dosage of 25,000 to 50,000 units is dissolved in one cubic centimeter of normal salt solution for the inhalation. This solution is atomized by a stream of oxygen which is inhaled by the recipient for a period of about ten minutes, usually four times a day. In hospitals, access can be had to large tanks of oxygen equipped with flowmeters to adjust the rate of flow; the flow of oxygen through the nebulizer is controlled by a Y-tube inserted in the circuit which allows the gas to be diverted to the outside during expiration.

The principal disadvantage of the method has been the necessity of being in the hospital to receive treatment, or the necessity of renting or buying the apparatus to use at home. Either one of these alternatives is very expensive. Added disadvantages are the weight and relative immobility of the units, which require two men and a truck to move. In addition, at least half of the oxygen or other gas is lost.

With the advent of a new and inexpensive portable unit which overcomes all of the above objections,[3] treatment can be carried out at home over short or long periods of time at very little expense. The method in general has the additional advantage of avoiding the frequent injections of these substances with accompanying pain, danger, cost, and monopoly of the physician's time.

This unit as illustrated (Figs. 1 and 2) consists of a light-weight tank with working mechanism attached to the nebulizer, so that the inhalation

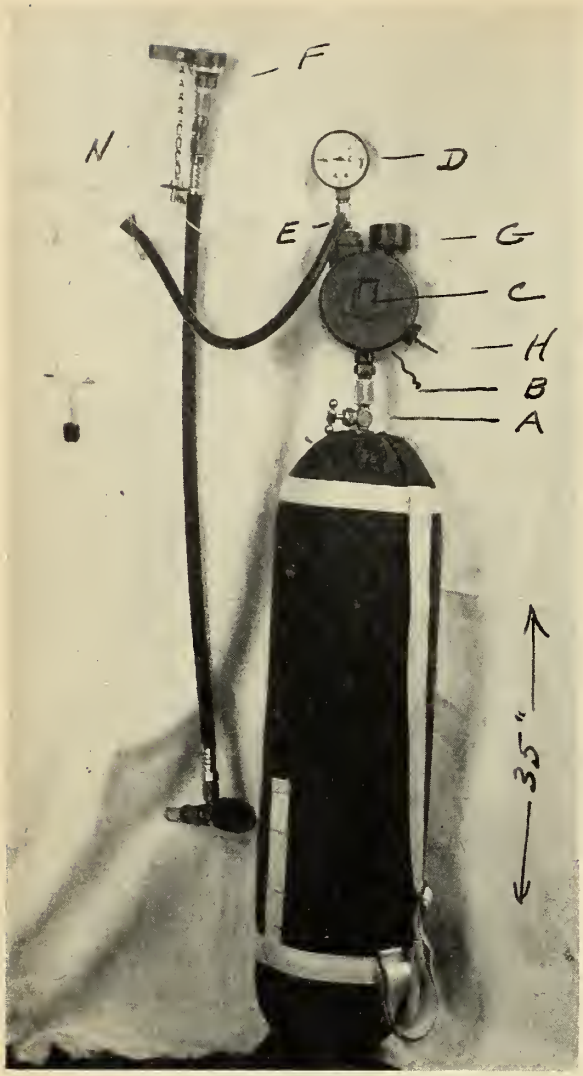

Fig. 1. Portable unit for aerosol therapy of upper respiratory infections. See description in text.

Fig. 2. Working mechanism of portable unit for aerosol therapy.

can be taken either in through the mouth or nose as desired. The entire apparatus weighs a trifle over eight pounds and can be lifted or carried easily in one hand. The capacity of the tank is sufficient for three or four days' use with four inhalations a day. No gas is wasted. It can be easily used while riding in automobiles, busses, trains, planes, or ambulances. The cost is roughly one-fourth that of the large apparatus. The operation consists of opening the valve *A* which allows the gas to enter the chamber *B*. Pressure on button *C* starts a flow of gas through the flowmeter *D* and outlet *E*, to the nebulizer *N* and through the mouth or through the nasal tubes into the nasal cavities. Release of pressure on button *C* stops the flow. *G* is a pressure gauge which registers the amount of gas and pressure (500 pounds) in the tank. Valve *H* and cable attached *F* allow refilling from a large tank in about a half a minute. Soluble tablets containing 50,000 units of penicillin each were used in this study.* These eliminate the nuisance of needles, syringes and vials previously needed for making the solution ready for nebulization. All that is necessary now is to drop a tablet into the nebulizer, add fifteen drops of normal salt solution to dissolve, and it is ready for use.

During the past year, a number of patients who came under the cold-susceptible and low-immunity group were given the treatment. They were urged to start with the first sign of a respiratory infection and continue until it was entirely cleared. In 95 per cent of the cases this resulted in a complete clearing of the process in from two to four days. None persisted for more than one week. A number of physicians including nose and throat specialists were in the group. The latter were amazed at the rapidity with which the infections cleared up as compared with their previous experiences.

*Supplied through the courtesy of Commercial Solvents Corp.

In another group of primary bacterial infections the results were equally satisfactory. Acute tonsillitis, pharyngitis, and laryngitis responded most rapidly, usually clearing in forty-eight to seventy-two hours. Acute bronchitis took three to four days, acute sinusitis from three to seven days. Several instances in which an acute flare-up of a chronic sinusitis occurred, cultures became bacteria-free, but the thickened, diseased membranes remained unaffected. One case of pneumococcus pneumonia (proven by x-ray and culture), in a patient with a decompensating mitral heart, cleared in forty-eight hours. Others cleared almost as rapidly when penicillin was administered by inhalation in addition to parenteral administration.

Some objections have been raised about treating the common respiratory infections with penicillin on account of rendering the organisms resistant. If enough penicillin is used, the organisms are entirely eliminated, which overcomes this objection. To be sure, penicillin does not eradicate the gram-negative and a few other organisms but these are not often the cause of respiratory infection. When they are, they can usually be eliminated by using streptomycin either alone, in combination with or alternating with penicillin.[5] There is no suggestion that there will not be recurrences of these infections. Some authorities warn that powerful agents such as the above should not be used in common respiratory infection, but if the authors of this suggestion were afflicted as some people are, they probably would be the first to advocate the practice.

There have been no serious reactions in this group. A few developed sore tongues, hives, and allergic manifestations, none of which were serious. In one instance the penicillin provoked bronchial spasm in an individual who had been eating a large amount of cheese and who obviously was quite sensitive to molds. It was necessary to de-sensitize this patient and two others who were allergic to penicillin to carry out the treatment.

The above method of treatment and the apparatus need not be confined to the treatment of respiratory infections. The unit serves as a quick, easy, portable source of oxygen in shock, coronary occlusion, and other emergencies. Adrenalin, aminophyllin,[6] and oxygen helium mixtures may be used for relief by asthmatics. Pyribenzamine may be used in the allergies, and is very effective in anaphylactic shock by inhalation. Streptomycin has been demonstrated to be curative in infections with hemophilus influenza and very valuable in clearing up the local lesions of tuberculosis in the upper respiratory passages.

Penicillin by inhalation will probably be the treatment of choice in scarlet fever and related streptococcus infections of the throat,[8] as well as a valuable adjunct in diphtheria. Its use in the secondary bronchial involvement of measles has not been tried to the writer's knowledge. It is helpful in the treatment of the chest complications of chronic cystic pancreatitis. In pneumonias caused by organisms sensitive to penicillin and streptomycin, its use should be almost mandatory. Oxygen-carbon-dioxide mixture is often used postoperatively to prevent atelectasis or massive collapse of the lungs, and carbon dioxide has recently been demonstrated to be perhaps the best expectorant and thinner of tenacious secretions available.[1]

Oxygen, air, or mixtures of oxygen and helium or oxygen and carbon dioxide can be used for nebulizing the medicament. The aerosol can be inspired through the nasal passages and expired through the mouth, or vice versa. Sometimes a combination of these is desirable.

References

1. Banyai, A. L.: Dis. of Chest, 13:1-17, (Jan.-Feb.) 1947.
2. Barach, A. L.: Penicillin inhalation therapy. Am. J. Med., 3:261-293, (Sept.) 1947.
3. Dwyer, H. V.: A portable apparatus for aerosol medication. Am. J. Med., 3:294, (Sept.) 1947.
4. Hinshaw, H. C., et al: Streptomycin in the treatment of tuberculosis. Am. Rev. Tuberc., 54:191-203, 1946.
5. Nicols, D. P., and Herrell, W. E.: Streptomycin. J.A.M.A., 132:200, (Sept. 28) 1946.
6. Prigal, S. G.: Aerosol penicillin. J.A.M.A., 134:932, (July 12) 1947.
7. Siegel, M. S.: Penicillin inhalation therapy. J.A.M.A., 134:762, (June 28) 1947.
8. U. S. Naval Hospital (Treasure Island, California) report: Scarlet fever. Am. J. M. Sc., 211:417, (April) 1946.
9. Vemilye, H. N.: Aerosol penicillin, J.A.M.A., 129:250, 1945.

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PARATHYROID EXTRACT

(Continued from Page 1401)

7. Collip, J. B.: Extraction of a parathyroid hormone which will prevent or control parathyroid tetany and which regulates level of blood calcium. J. Biol. Chem., 63:395, 1925.
8. Ellsworth, R.: Studies on physiology of the parathyroid glands. V. Action of parathyroid extract on the renal threshold for phosphorus. J. Clin. Investigation, 11:1011, 1932.
9. Goodman, L., and Gilman, A.: Pharmacological Basis of Therapeutics. P. 600. New York: McMillan Company, 1941.
10. Hoff, H. E.; Smith, P. K., and Winkler, A. W.: Electrocardiographic changes and concentration of calcium in serum following intravenous injection of calcium chloride. Am. J. Physiol., 125:162-171, 1939.
11. McCann, W. S.: Diuretic action of parathyroid extract-Collip in certain edematous patients. J.A.M.A., 90:249, 1928.
12. Rockwood, R., and Barrier, C. W.: Calcium treatment for edema. Arch. Int. Med., 33:643, 1924.
13. Selye, H.: Mechanism of parathyroid hormone action. Arch. Path., 34:632, 1942.
14. Sevringhaus, E.: Endocrine Therapy in General Practice: Parathyroids. P. 79. Chicago: Year Book Publishers, 1940.

Second Annual
MICHIGAN POSTGRADUATE CLINICAL INSTITUTE

Grand Ballroom, Book-Cadillac Hotel, Detroit
March 10-11-12, 1948

Time	Wednesday March 10, 1948	Thursday March 11, 1948	Friday March 12, 1948
A.M. 8:30- 9:00	Registration Exhibits Open	Registration Exhibits Open	Registration Exhibits Open
9:00- 9:20	Obstetrics-Gynecology Harold Henderson, M.D. Detroit	Medicine Kenneth Corrigan, Ph.D. Detroit	General Practice R. K. Dixon, M.D. Detroit
9:20- 9:40	Surgery Cameron Haight, M.D. Ann Arbor	Surgery R. W. Buxton, M.D. Ann Arbor	Surgery H. M. Nelson, M.D. Detroit
9:40-10:00	Pediatrics Saul Rosenzweig, M.D. Detroit	Obstetrics R. L. Haas, M.D. Ann Arbor	Obstetrics H. H. Cummings, M.D. Ann Arbor
10:00-11:00	Intermission to View Exhibits	Intermission to View Exhibits	Intermission to View Exhibits
11:00-11:20	Medicine R. M. Eaton, M.D. Grand Rapids	Anesthesia N. M. Bittrich, M.D. Detroit	Pediatrics H. A. Towsley, M.D. Ann Arbor
11:20-11:40	Orthopedics A. G. Goetz, M.D. Detroit	Surgery Matthew Peelen, M.D. Kalamazoo	Urology H. L. Morris, M.D. Detroit
11:40-12:00	Allergy J. M. Sheloon, M.D. Ann Arbor	Medicine W. D. Robinson, M.D. Ann Arbor	Medicine F. H. Top, M.D. Detroit
P.M. 12:00- 2:00	Luncheon F. A. Coller, M.D. Ann Arbor	Luncheon H. F. Vaughan, Dr. P.H. Ann Arbor	Luncheon J. S. DeTar, M.D. Milan W. B. Harm, M.D. Detroit
2:00- 2:20	Surgery W. H. Meade, M.D. Lansing	Psychiatry R. W. Waggoner, M.D. Ann Arbor	Cllinical-Pathological Conference (A Medical Case) conducted by F. W. Hartman, M.D. Detroit
2:20- 2:40	Medicine W. S. Reveno, M.D. Detroit	Pediatrics Frank VanSchoick, M.D. Jackson	
2:40- 3:00	Syphilology L. W. Shaffer, M.D. Detroit	Surgery R. J. Noer, M.D. Detroit	General Practice L. G. Christian, M.D. Lansing
3:00- 4:00	Intermission to View Exhibits	Intermission to View Exhibits	3:00-3:40 Final Intermission to View Exhibits 3:40-4:00 Thoracic Surgery Richard Meade, M.D., Grand Rapids
4:00- 4:20	Dermatology Edw. P. Cawley, M.D. Ann Arbor	Ophthalmology A. D. Rueedemann, M.D. Detroit	Medicine F. A. Weiser, M.D. Detroit
4:20- 4:40 4:40- 5:00	Clinical X-Ray Conference conducted by F. J. Hodges, M.D. Ann Arbor	Clinical Pathological Conference (A Surgical Case) conducted by O. A. Brines, M.D. Detroit	Gynecology J. P. Pratt, M.D. Detroit Otolaryngology A. C. Furstenberg, M.D. Ann Arbor
6:30	Dinner Hour	Dinner Hour	Institute Ends at 5:00 P.M.
8:00-10:00	Question Box Moderator E. D. Spaloing, M.D. Detroit D. H. Kaump, M.D. Detroit H. J. VandenBerg, M.D. Grand Rapids M. F. Osterlin, M.D. Traverse City W. F. Seeley, M.D. Detroit 10:30 P.M. Smoker Entertainment	Panel Discussion "First Aid to Acutely Injured Patient" Moderator G. C. Penberthy, M.D. Detroit C. R. Keyport, M.D. Grayling F. N. Smith, M.D. Grand Rapids W. M. Tuttle, M.D. Detroit H. F. Falls, M.D. Ann Arbor G. J. Curry, M.D. Flint J. E. Webster, M.D. Detroit	No Registration Fee at the Postgraduate Institute

President's Page

Holiday Greetings

ONCE more we approach the Holiday Season with its pleasant custom of greeting our friends. This year it is my special privilege to greet you through the medium of the President's Page.

That each of you may be able to spend Christmas at home with his loved ones, and that the coming year may bring health and happiness in generous measure to you and your families, is my sincere wish.

P. L. Sedwidge

President, Michigan State Medical Society

Editorial

BLUE CROSS—A PUBLIC TRUST

SENATOR ARTHUR H. VANDENBURG met with a group of Michigan State Medical Society officials as well as representative officers of Michigan Medical Service in Grand Rapids on October 30, 1947, at an informal private dinner. He told us that he is unalterably opposed to socialized medicine, but must have some help in his fight on that issue. He hopes to see something done that will make any socialized medicine experiment unnecessary. Everyone will admit that there is a justifiable demand for relief from increasing health costs, especially when they become catastrophic for individual families. For these many years nothing was done generally to alleviate this problem. The medical profession, local and national, has opposed national programs looking to any form of state medicine, but the demand recurred. The Senator told us that we have approached the matter from the wrong angle.

The way to defeat a program is not so much to oppose it as to make it unnecessary—to propose a substitute that is better, works easier, and does not disrupt existing economy. The medical profession of Michigan has done one of the most stupendous pieces of socio-economic study that has ever been done without the aid of government or help of substantial subsidy. It has been done by private effort and with amazingly little capital.

The medical profession of Michigan has shown that it has the vision to foresee a great social need, and to provide the solution. It has the medical and scientific resources, and has provided on an insurance basis methods to make that knowledge and skill available to the most modest and foresighted person, at a price within reach. Michigan has shown that the socio-economic needs of her people can be solved by the very men most able and best equipped to understand the situation—who know the need, and the remedy.

The Senator said, "You in Michigan have the answer to socialized medicine, have proved it to a quarter of the population of the state, but while doing a magnificient job, have done it quietly and under cover, as it were. You have been afraid of publicity, the one thing you must have if you are to avoid socialized medicine. You would be amazed at how easy socialized medicine could be put across, even with all the vast sums spent in opposition. The medical profession has muffed the ball."

The Senator told us that he is astounded at the accomplishment of setting up the study and working out the experiment to a success, in making it available to anyone who wishes to use it, and of maintaining the American ideals of voluntary effort. But the medical profession has failed to appreciate that in what it has done it has established the greatest "public trust" in Michigan. By that very fact, the profession has assumed a responsibility to the public growing out of this trust. All public trusts owe the people reports of their stewardship. They have taken the public's money and expended it, and naturally owe the people an accounting. The Michigan medical profession has used an immense amount of the people's money and has failed to tell what they did with it.

As trustees of such a great public trust, the Senator said, the profession must take the public into its confidence and make periodic reports. Such publicity is a public duty, not the advertising of an appendix operation, or the merits of Doctor Jones. We must discharge that duty so efficiently that every individual will know the results in spite of himself. Such publicity will effectively forestall any socialized medicine plan that may be proposed.

The Senator says that what he wants as part of his fight to prevent socialized medicine is glaring publicity of the things we have done so unbelievably well in Michigan.

STOCK TAKING

ANOTHER YEAR is drawing to a close, and like all well-conducted business, the medical profession should take stock. Has the year now nearing its end been one of progress? Has that progress been as great as it should have been? We have had one of the greatest annual sessions in our history. We have reconstructed from the war period, and returned to active civil life. Our doctors are practically all back home doing the things they have wished and prepared themselves to do.

Michigan Medical Service, the great socio-

economic expression of our attempt to find a solution to the demand for better and more widespread health service for people primarily of moderate income, has grown and prospered. It is way beyond the experiment stage, and now provides surgical, medical, obstetric or emergency care for almost one million of our population. The corporation is solvent, with a growing reserve, and is meeting all its obligations as soon as the reports can be processed.

Michigan Medical Service has carried the Veterans Administration program in the plan for home-town care of veterans. This is the Michigan plan, first proposed by us, and adopted by the Veterans Administration. Michigan Medical Service, through its co-operating physicians, cares for the veteran with his service-connected disability, pays the bill, then each month sends the consolidated account to the Veterans Administration for reimbursement. Many times that account has been over a third of a million dollars—a service we have gladly done, but one that tied up a lot of money. Fortunately, we had the reserve and could make it available for services to the veteran.

The Michigan State Medical Society held a most successful Postgraduate Clinical Institute in March, with a program arranged for presentation by Michigan doctors as the speakers. The conference was attended by 1,293 physicians—a surprising number of Michigan and out-of-state doctors. Another such program is in the making for the year 1948.

The Michigan State Medical Society has expanded its program of public relations with success, and has been paid the compliment of being copied by some eighteen states. This program will be continued and extended during the next year.

In September, 1947, the Michigan State Medical Society, through its Public Relations Committee and in co-operation with the Michigan State College and a group of sponsoring agencies, held a Michigan Rural Health Conference, with over 400 persons in attendance. The mectings were comprehensive in the coverage of rural health problems, were enthusiastically received, and will be repeated in 1948.

These are just a very few of the activities of the medical profession during the year just ending, but added to the furthering of plans started in other years they make a formidable showing of which Michigan Medicine may well be proud.

NURSING SERVICES

THE PRESIDENT of thc American Medical Association, Edward Bortz, M.D., has appointed a committee to survey the nursing problem in the United States, and that committee is now engaged in its studies. The situation is critical. There are not enough nurses. The field of nursing is attractive, and in the past has drawn many students, but the work in the main is only temporary. The loss of personnel is great—into doctors' offices, into industry, into health services, but most of all, into their own new homes and families.

Recruitment has not been sufficient to begin to keep pace with new demands. The practical nurse of the earlier times has come into much more demand, and is being welcomed by the nursing profession. An article by Grace Ross, R.N., bearing on this subject, and telling what is being done in Michigan to advance that phase of nursing, appears in this issue (Page 1395).

Every effort of medical societies, of hospital administrators, of nursing groups, and of kindred organizations such as the Medical Auxiliary, is needed to meet the growing needs. Hospitals have whole wards and floors closed because of inability to get nursing staffs sufficient to take care of the additional beds. The Army has been calling for additional nurses. The Michigan State Medical Society has had a Committee on Nurses Training Schools, but we need the active help of all our members, when the occasion presents, to encourage young women to enter the nursing profession.

CONGESTIVE HEART FAILURE

(Continued from Page 1395)

25. Pines, I.; Sanabria, A., and Arriens, R. T. H.: Mercurial diuretics; addition of magnesium sulfate to prevent toxic effects of their intravenous administration. Brit. Heart J., 6:197, 1944.
26. Ruskin, A., and Herrmann, G. A.: Studies in combined diuretic therapy. J. Lab. & Clin. Med., 29:486-492, (May) 1944.
27. Schemm, F. R.: A high fluid intake in the management of edema, especially cardiac edema. 1. The details and basis of the regimen. Ann. Int. Med., 17:952-969, 1942.
28. Schemm, F. R.: A high fluid intake in the management of edema, especially cardiac edema. 2. Clinical observations and data. Ann. Int. Med., 21:937-976, 1944.
29. Schemm, F. R.: A high fluid intake in the management of edema. Journal-Lancet, 66:50, 1946.
30. Schroeder, H. A.: Studies on congestive heart failure; importance of restriction of salt as compared to water. Am. Heart J., 72:141-153, (Aug.) 1941.
31. Scott, John W. (Lexington, Ky.): Personal communication to the author.
32. Shaffer, Carl F.: Diuretic effect of ascorbic acid. J.A.M.A., 124:700-701, (March 11) 1944.
33. Stroud, William B.: The Diagnosis and Treatment of Cardiovascular Disease. Vol. 2, pp. 1087-1091. Philadelphia: F. A. Davis Co.
34. Swigert, V. W., and Fitz, R.: Effect of mersalyl (salyrgan) on plasma volume. J.A.M.A., 115:1786-1790, (Nov. 23) 1940.
35. Wexler, J., and Ellis, L. B.: Toxic reactions to intravenous injection of mercurial diuretics. Am. Heart J., 27:86-95, (Jan.) 1944.
36. White, Paul D.: Heart Disease. Third edition pp. 782-785. New York: Macmillan Co.

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MICHIGAN STATE MEDICAL SOCIETY

Eighty-second Annual Session

PROCEEDINGS OF THE HOUSE OF DELEGATES

Pantlind Hotel, Grand Rapids, Michigan

(Continued from the November issue)

Third Meeting

Monday Evening, September 22, 1947

The meeting convened at 8:30 p.m., Dr. J. S. DeTar, Speaker of the House of Delegates, presiding.

THE SPEAKER: Does the Chairman of the Credentials Committee have a report to make?

J. J. O'MEARA, M.D.: I have eighty-two credentials, which are more than a quorum, 50 per cent of whom are not from any one county.

THE SPEAKER: The report of the Credentials Committee will be accepted as the roll call.

Before the recess this afternoon Dr. Breakey made a motion that the first order of business this evening should be a report of the Reference Committee on Resolutions. Dr. Breakey will give the report of the Reference Committee on Resolutions.

XII—f. ON RESOLUTIONS

R. S. BREAKEY, M.D.: Your Reference Committee on Resolutions has completed its assigned duties to date.

We will take up these resolutions in the order chosen and not necessarily as they were introduced.

XII—f. ON CANCER DETECTION CENTERS

The resolution submitted by Dr. Hull of Wayne County concerning cancer detection centers—and I shall read the "Resolved" part only—is as follows:

"RESOLVED: That the Michigan State Medical Society does reaffirm its purpose to stimulate, encourage and assist all proper measures for the detection, study, treatment and control of cancer; and be it further

"RESOLVED: That each county or district medical society of Michigan, either by itself or in conjunction with the surrounding county groups, is urged to create facilities for the appropriate handling of the cancer problem, and that it be responsible for cancer activities in its own area; and be it further

"RESOLVED: That these facilities be used for the detection of cancer among those who are not able to employ the services of a doctor of medicine; and be it further

"RESOLVEN: That any expansion or alteration of such a program be undertaken only by the approval of the county medical society."

Your Committee unanimously approves this resolution, and as Chairman I move its adoption.

T. Y. Ho, M.D. (Clinton): I second the motion.

(The motion was put to a vote and was carried unanimously.)

XII—f. ON SEMI-ANNUAL MEETINGS OF HOUSE OF DELEGATES

R. S. BREAKEY, M.D.: This resolution was introduced this afternoon by Dr. Krechmar of Genesee County:

"WHEREAS, the volume of business transacted by the House of Delegates of the Michigan State Medical Society has been increasing steadily during the past several years, and

"WHEREAS, the interval of time between annual sessions is often too long to give proper attention to the problems at hand, and

"WHEREAS, the Annual Michigan Postgraduate Institute meets during the spring months; therefore, be it

"RESOLVED: That henceforth a semi-annual meeting of the House of Delegates shall be held during the time of the Annual Postgraduate Clinical Institute, to transact such business and to consider such resolutions as may be presented at that time."

This resolution is in two parts. The Committee considered that as part 1.

"In order to transact such business and to consider any resolutions that may be presented, be it

"RESOLVED: That a special meeting of the House of Delegates be called at the time of the meeting of the Michigan Postgraduate Clinical Institute for 1948."

Your Committee considered that the first part of this resolution involved a change or revision in the By-Laws. The second part is pertinent since it pertains particularly to a proposed meeting to be held next spring, and the calling of a special meeting within the province of the committee of reference.

As to the first part of this resolution, the Committee recommends its approval following referral to the Committee on Amendments to the Constitution and By-Laws.

As to the second part, which calls specifically for a single meeting to be held in 1948, your Committee moves its adoption.

C. L. WESTON, M.D.: I second the motion.

THE SPEAKER: This motion involves two resolutions. We will take up the second one first, if it is agreeable with the House, that a special meeting of the House of Delegates be called at the time of the Postgraduate session in the spring of 1948. If it is agreeable we will open this for discussion. We will vote on these separately. Is there any discussion on the motion?

L. G. CHRISTIAN, M.D.: Mr. Speaker, what does the Constitution or By-Laws say about the calling of a special session?

THE SPEAKER: The By-Laws, which can be changed by any motion without previous publication of it, say this on page 121: "The House of Delegates shall meet annually at the time and place of the annual session, and may hold such number of meetings as the House may determine or its business require, adjourning from day to day. . . ." I believe that is all. However, the By-Laws may be amended on the vote of the House at any time.

R. S. BREAKEY, M.D.: Pardon me, Mr. Speaker. In answer to Dr. Christian's question, your Committee pursued the By-Laws relative to this matter, and any special meeting may be called by the House of Delegates itself at any time; or a special meeting may be called by the officers of the Society upon a certain number of days' notice. It is within the By-Laws for this House to call itself into special session at any time for any period, from thirty days on.

THE SPEAKER: The motion before the House is to call a special meeting of the House of Delegates next spring, at the time of the scientific session.

L. G. CHRISTIAN, M.D.: Section 3: "Special sessions of the House of Delegates shall be called by the Speaker on the petition signed by two-thirds of the Delegates seated at the last annual session of the House."

THE SPEAKER: Also, if you will turn to the very last page on amendments, "These By-Laws may be amended by a majority vote of the delegates seated, after the proposed amendment is laid on the table for one meeting." That means this meeting tonight. It could be taken up at tomorrow morning's meeting and voted on.

The question before the House is whether to hold a special session during the spring meeting of 1948 at the time of the Postgraduate conference. Is there any further discussion?

H. H. RIECKER, M.D.: Can anyone inform the delegates of the cost of holding a meeting of the House of Delegates?

THE SECRETARY: I don't think I can give you those figures. The costs have not been segregated with regard to any particular phase of the state meeting. The present state meeting costs about $7,000, which involves the whole picture. We have never broken down the House of Delegates or this or that. We could probably get the figures later.

L. W. GERSTNER, M.D.: At the moment is there any anticipated need for such a meeting next spring?

THE SPEAKER: Dr. Breakey, will you answer that question by telling us what transpired at your meeting?

R. S. BREAKEY, M.D.: Do you mean whether there is any anticipated business, Doctor? Is that what you mean?

L. W. GERSTNER, M.D.: Is there any one piece of business that would make it urgent that we hold such a meeting?

R. S. BREAKEY, M.D.: Your Committee is only acting on this resolution. I do know that there are two reports which were not given because they were continued and the committees were in action. I am speaking now as a member of the House. Those reports were given and not considered by this House, and were referred to future meetings of the House of Delegates.

I shall read this again: "The volume of business transacted at the Michigan State Medical Society has been increasing steadily." It is not my province, I believe, to plead the cause of this resolution, but the Committee unanimously adopted it, and I personally know that once this House used to have three meetings; now it has four. In Detroit I had to sit up until 3:30 one morning with the rest of you, and two-thirds of the House walked out on that meeting.

Personally, I know the business is increasing. I think this is meant to facilitate the mechanism of the business of the Society, and so your Reference Committee thought. That is all we can say.

L. G. CHRISTIAN, M.D.: Mr. Speaker, I am not attempting to be an obstructionist, but you say in the By-Laws they can be amended. There is nothing in the By-Laws that a hasty review shows stating anything about special meetings. Can you find it?

THE SPEAKER: The By-Laws may be amended.

L. G. CHRISTIAN, M.D.: There is nothing in the By-Laws now.

R. S. BREAKEY, M.D.: You are not delaying it.

L. G. Christian, M.D.: I am delaying it. I want it to be right.

The Speaker: The first part of the resolution is an amendment to the By-Laws; is that right, Dr. Breakey?

L. G. Christian, M.D.: That isn't what he said.

R. S. Breakey, M.D.: I shall read this again:

"Whereas, the volume of business transacted by the House of Delegates of the Michigan State Medical Society has been increasing steadily during the past several years, and

"Whereas, the interval of time between annual sessions is often too long to give proper attention to the problems at hand, and

"Whereas, the Annual Michigan Postgraduate Institute meets during the spring months; therefore, be it

"Resolved: That henceforth a semi-annual meeting of the House of Delegates shall be held during the time of the Annual Postgraduate Clinical Institute, to transact such business and to consider such resolutions that may be presented at that time."

Your Committee felt that this involved an amendment to the By-Laws, and recommends its approval following referring this first part of the resolution to the Committee on Amendments to the Constitution and By-Laws.

L. G. Christian, M.D.: You are ad libbing now. You didn't say that before.

R. S. Breakey, M.D.: I did say that before. Mr. Speaker, did I say that before? I read the whole thing, then I said "part 1" and "part 2."

L. G. Christian, M.D.: Okay; I apologize to the Chair.

C. L. Weston, M.D.: Mr. Speaker, if I may refresh the memory of the Chairman, I believe the decision of the Committee this afternoon was based upon Section 2, Article VII of the Constitution, page 115 in the Handbook.

The Speaker: Do you care to read it, Dr. Weston?

C. L. Weston, M.D.: "Special sessions of the Society shall be called on the petition of the Council, or by a petition signed by 250 members or upon petition of two-thirds of the delegates seated at the previous annual session. The call for regular and special session shall be issued by the President and Secretary, complying with these provisions not later than ten days after receiving the petition, and shall go forth not later than thirty days before the proposed date of holding a regular or special session."

The Speaker: Let's get through this as quickly as possible, gentlemen. I will ask Dr. Breakey to answer that particular question.

R. S. Breakey, M.D.: That point which we recommended for approval after reference to the Committee on Constitution, is not the matter under consideration by Order of the Chair. He has proposed consideration of part 2 of this resolution, which reads as follows—this being pertinent to what Dr. Weston has just read, and as authorized by two-thirds vote of this meeting; this is not an amendment to the Constitution and By-Laws:

"In order to transact such business and to consider any resolutions that may be presented, be it

"Resolved: That a special meeting of the House of Delegates be called at the time of the meeting of the Michigan Postgraduate Clinical Institute for 1948."

That, as we understood it, specified a particular, single meeting at a given time. The Chair has ruled that we will consider this part first.

The Speaker: The question under discussion is that we call a special session of the House of Delegates next spring.

T. K. Gruber, M.D.: Mr. Speaker, if the first part of that resolution is presented as an amendment to the By-Laws tonight, it can be voted on tomorrow and becomes an amendment, and you will set up two sessions of the House.

The Speaker: That is right.

T. K. Gruber, M.D.: That would not be a special session.

The Speaker: That is right.

T. K. Gruber, M.D.: On page 115, Section 3 says: "Special sessions of the House of Delegates shall be called by the Speaker on the petition signed by two-thirds of the delegates seated at the last annual session of the House." That would have no bearing if we passed this amendment, and then tomorrow you can put in the rest of it and arrange for the meeting next spring.

The Speaker: That is right.

T. K. Gruber, M.D.: The latter part should not come up tonight, but should wait until after the first part is passed tomorrow.

The Speaker: Then, gentlemen, if it is agreeable, we will reverse the procedure and we will vote on the first part, which is a motion to refer this proposition to the Reference Committee on Constitution and By-Laws tonight. If there is no objection we will proceed to the vote on the first part of this resolution. If it is passed we will refer it to the Reference Committee on Constitution and By-Laws for consideration and a report tomorrow.

T. K. Gruber, M.D.: It does not require a vote. The Speaker of the House can refer anything to whatever committee he chooses.

The Speaker: The Chair would like to have the opinion of the House in this matter, and will ask for a vote. The Chair feels the House is in session and we should have an opinion from the House.

Is there any further discussion on the motion to refer this to the Reference Committee on Constitution and By-Laws?

(The motion was put to a vote and was carried by a vote of 58 to 12.)

The Speaker: The motion is passed. Is there further business?

R. S. Breakey, M.D.: I take it that as far as item 2 is concerned on this, it is taken care of; right?

The Speaker: Automatically it will be taken care of until after the vote tomorrow.

XII—f. ON SALARY INCREASE TO MEDICAL OFFICERS IN ARMED FORCES

R. S. Breakey, M.D.: This resolution is submitted by Dr. Texter of Wayne County:

"WHEREAS, the House of Delegates of the American Medical Association at its meeting in Atlantic City publicly announced a desire to elevate the standing of the general practitioner in the eyes of the lay public and the medical profession, and

"WHEREAS, the sentiment of all concerned at the Atlantic City meeting was to the effect that all doctors of medicine should have equal professional and financial opportunity regardless of what branch of the healing art they practiced, and

"WHEREAS, when a congressional bill was presented in which it was proposed that there be a differential in pay between so-called specialist officers and nonspecialist officers in the military forces, the delegates contradicted their expressed views and approved this bill, and

"WHEREAS, the differentiation in rank and pay between these two groups in the recruiting of medical officers in the late war was one of the greatest sources of dissatisfaction, and

"WHEREAS, in peace time the military services have the time and finances to develop specialists among its various personnel at governmental expense, in accordance with the ability shown; therefore, be it

"RESOLVED: That the American Academy of General Practice of Wayne County voice its approval of an increase in pay to medical officers of the armed services in general, but demand that no differentiation be made between so-called specialists and nonspecialists; and be it further

"RESOLVED: That a copy of this resolution asking for this approval be sent to the Board of Trustees of the American Medical Association, the Board of Directors of the American Academy of General Practitioners, the House of Delegates of the Michigan State Medical Society, and the Council of the Wayne County Medical Society."

Your Committee sees in this no resolution which is applicable to the proceedings of this House, since it is a matter of record of the American Academy of General Practice of Wayne County which has fulfilled its obligation in sending copies of their approved resolution to the House of Delegates of the Michigan State Medical Society. Nowhere in this resolution does it request action by this House.

Your Committee therefore recommends that this be received in the name of the House of Delegates. I so move.

S. L. Loupee, M.D.: I second the motion.

E. D. Spaulding, M.D.: A point of order. The resolution has been received.

The Speaker: The resolution has been received. There is no motion that any action be taken. If any delegate cares to amend the motion to the effect that any motion be taken, the Chair will be glad to receive such a motion.

R. S. Breakey, M.D.: Mr. Chairman, your Committee merely wanted to show appreciation and courtesy to the members of the General Practice group who have submitted this from Wayne County. If this is formally received and filed, as the Speaker suggests, it will be a matter of record, and the man will be accredited with having followed his instructions. If we don't make it a matter of record he will be in the doghouse when he gets home.

W. B. Harm, M.D.: I can explain that motion. The motion was put before the American Academy of General Practitioners of Wayne County because of the fact that there is a bill before Congress in which all medical officers would receive $100 a month more than line officers of similar rank. Under that bill the Secretary of War can designate certain officers as specialists. There is a similar bill for the Navy.

These officers who are in that specialist rating named by a layman who is secretary of the bureau in charge of the armed forces, will receive a 25 per cent increase in base pay and allowances, which is an unfair discretion between the groups.

The fact is that specialists and general practitioners and specialists going into the Army caused a great deal of dissatisfaction among the members in the last war who were recruited into the service. This resolution was introduced to the Academy, and the Resolved portion of it should have been reworded. Because of the lack of rewording I believe the action of the Committee is well taken.

The Speaker: The motion is that the resolution be received and filed. Is there any further discussion?

(The motion was put to a vote and was carried unanimously.)

XII—f. Rh FACTOR DETERMINATION BY STATE HEALTH DEPARTMENT

R. S. Breakey, M.D.: The following resolution was introduced by Dr. Wiley upon instructions of the Ingham County Medical Society:

"WHEREAS, the State Department of Health Laboratories have been rendering a valuable and continuing service to the people and physicians of Michigan in testing blood for Rh factor and Rh titer determinations, and

"WHEREAS, it is the unanimous opinion of the medical profession that these determinations are very important in cases of expectant mothers, newborn infants and in all transfusions; therefore, be it

"RESOLVED: That it is the urgent desire of this Society that this service be continued to the people and to the physicians of Michigan; and further be it

"RESOLVED: That the Ingham County Medical Society instruct its delegates to take this resolution to the meeting of the House of Delegates of the Michigan State Medical Society in Grand Rapids, September 21-23, and urge its adoption."

Your Committee unanimously recommends this resolution for adoption, and I so move.

L. G. Christian, M.D.: I second the motion.

C. I. Owen, M.D.: Mr. Speaker, my first objection to this is the fact that it was referred to a Committee whose Chairman is a member of the Ingham County Medical Society.

As a pathologist and as a delegate I am objecting to this resolution getting the okay of this House of Delegates. The Michigan State Medical Society is spending thousands of dollars on public relations, and one of the things we are involved in is the inroads of the government into medicine. We pathologists believe this is one step you are asking the government to do something for free, and it is only one more step to ask them to deliver the babies for free, and then give them free appendices and then a free automobile.

The first resolution this morning was offered as a matter of encouraging the prosecution of people who use government funds to promote state medicine. This resolution, if adopted, will promote that very thing.

The proponents of state medical propaganda lay awake nights thinking up things. I am not saying they thought this up, but they have thought up a lot of things, and sometimes we as a group of pathologists find out some things in advance that are going on. For that reason I am voicing a public objection.

H. W. Wiley, M.D.: We have no fight with the pathologists whatever, but all we ask for in the Ingham County Medical Society is that this service be continued to us, and also be available to any people in the state who wish it.

I would like to know on whose authority Dr. Owen makes the statement that this "will promote socialized medicine." On whose authority—his own or the vote of someone?

The Speaker: Dr. Owen, will you answer that?

C. I. Owen, M.D.: It is my opinion.

The Speaker: He says it is his own personal opinion. Is there any other discussion on this resolution?

S. W. Insley, M.D. (Wayne): Mr. Speaker, I agree largely with what Dr. Owen said in this particular matter. I think all of us in this room will admit there are a number of these very things being performed by those people; but are we to turn around and put ourselves definitely on record as a body, making a formal request to the Board of Health to step into a branch of medicine?

It is one thing to let the thing sort of drift along; it's another thing to put ourselves on record asking for trouble.

L. G. Christian, M.D.: I am not an obstetrician, and I use the Rh factor only when my patients need blood transfusions. I think I can tell you how this came about. Harold Wiley didn't quite tell you the story.

The State Laboratory was practically driven into this by us fellows who live in Ingham County asking for it. We asked for this service because many of our patients (and, I am told by the obstetricians, many of the pre-natal care patients) are unable to pay the pathologists that Dr. Owens represents the $5 that is necessary.

There is nothing different from getting an Rh factor on the blood in pre-natal care than there is in accepting the Kahn test for syphilis.

I believe this is a service that you don't have to take. You can ask for it; you can send the bloods to the private laboratories if you wish; you can send them to the pathologists if you wish, but I believe (and it is my firm conviction) that it will make better doctors of us.

I believe that in ten years a doctor will not do a complete physical examination on his patient without knowing the blood grouping of that patient and her or his Rh factor.

I am carrying no torch for the State Laboratory. In fact, I have been assured by its director that he would like to get rid of it, and he doesn't want to encroach upon the practice of medicine. I can assure you from personal contact with this man that he is not attempting to get into the practice of medicine, and that he would like to get rid of it.

We of Ingham want that service, and we believe it will be a good thing for the doctor and for the patient. I have been in the practice of medicine long enough to know that what is good enough for the people will eventually be good enough for the doctor, and will make for better medicine.

I believe this should be adopted. I think public relations—why, just think about it! You remember when we had the fight—when the State Department of Health brought out the antitoxin for diphtheria. Do you remember the pharmaceutical houses? We went through it in the House of Delegates. The pharmaceutical houses didn't think the state should furnish free serum. We have practically eliminated diphtheria from this state.

I know from personal experience that the Rh factor rendered free to the patient saved lives in three cases in my own personal experience.

Gentlemen, we are talking about public relations. Now we are going to say, "Gosh! The pathologists will get $3 or $5." What is good for the public is good for the doctor, and that applies to socialized medicine, which I certainly am against because I don't believe soclialized medicine will ever be good for the public, and that is why I am against it.

After all, free inoculation of typhoid can be had from the state. You can get typhoid vaccine and smallpox vaccine and diphtheria antitoxin from the state. They did furnish a pneumococcic serum. Was that wrong? Did that harm us?

I hope we will not take a selfish view of this. I trust this is good public relations, and let's not allow the press and the people of Michigan to think we want a $3 or a $5 fee, because I know our patients can't take it.

The Speaker: Before I ask for further discussion I should like to ask Dr. Foster to tell us the decision of The Council on this matter. This was brought before The Council a month or so ago.

The Secretary: Mr. Speaker and members of the House, this matter came before The Council a month or two ago, and the action of The Council was to the effect that this service was approved by The Council in those areas where there were no established laboratories on a private basis, and in those cases where by means test there was no other way for the people to get the service.

The Speaker: Is there further discussion on the motion?

W. L. Brosius, M.D. (Wayne): I would like to second what Dr. Owen and Dr. Insley have said, and the action of The Council.

This apparently is an Ingham County matter. They are having difficulty. Ingham County is only one county in the state. There are many counties in the state that do not have that difficulty, and are getting along perfectly all right, and yet we as a deliberative body are asked to put our request before the State Laboratory for this service. I hardly think it is fair to the rest of the state to put such a thing in our minutes as a request for free tests—not that we want the $3, and may I say for the pathologists that they are glad to do that test as they do others, for nothing when the patient is not able to pay for it, and they are still doing it regardless of whether the state is doing it for free or not.

It isn't a matter of dollars and cents. I am a little sorry to hear that brought up. It is a matter of principle. I would like to see it defeated.

H. A. Furlong, M.D. (Oakland): Mr. Speaker and members of the House, I would like to speak on this matter as an obstetrician. I am very sorry that my friend and colleague of many years' standing has seen fit to wave a red herring under our noses, speaking of the dangers of socialized medicine.

If it were just a matter of the one initial Rh determination, I think that could be taken care of very well locally. It is being done in both of our local hosoitals in Pontiac. As a matter of fact, it is a practice in my office to refer all pre-natal cases for their preliminary Rh determination to a private laboratory. But that isn't the end of this business of the Rh factor in obstetrics.

If you are going to follow this thing to its logical conclusion, you will find that you are not only going to ask for one Rh determination, but you are going to be sending bloods back for an antibody Rh titer, and that sometimes requires a great many specimens, which I do not feel at the present time we can ask a great many people in the industrial centers to pay for. Maybe they should pay for them, but it is a burden upon them which at the present time I don't feel we should ask them to pay for.

Furthermore, that service is not available to us. We have to send it either to the Michigan State Health Department or to the ortho-gynecological research outfit at Lake Lindon with Dr. Diamond and Dr. Levine. That is the only place we could get it done.

If you are going to cut off a service to us which we think should be available to us in the practice of the best type of obstetrics, I am going to stand up here and fight you until there is no one left but me to breathe. I won't stand for it! It is the stinkingest piece of public relations we could bring up at this time!

Here is something that every woman who is going to have a baby in the State of Michigan is getting thrown at her from every popular magazine she picks up. The first question she asks nowadays is, "What about my Rh factor?" We had better be prepared to see that she is taken care of properly. I don't think you can ask some of these people to pay $25 or $30 to have the necessary antibody titers made on their blood. If you are going to be really scientific about this thing, it isn't enough to know what her antibody titer is at the seventh month, but maybe every week, until you decide whether it is bad enough for you to induce labor or to do a section, or whatever you are going to do.

I think the pathologists have taken a very shortsighted view in asking us to cut off this service to the people of Michigan at the present time.

Thank you very much.

W. L. Brosius, M.D.: With due regard for the matter that has been presented to the House, I certainly do not want to appear, as a pathologist, to oppose Rh tests. I would like to ask for my own information and the information of the House, if the

State Laboratory has refused to continue these tests in areas where it is not available, unless this House requests its continuance?

THE SPEAKER: Whom would you like to ask?

W. L. BROSIUS, M.D.: Anyone who has that information.

THE SPEAKER: Does anybody have that information?

H. W. WILEY, M.D.: I don't know whether they have refused to do it so far, but our resolution came out because of the fact that we learned The Council had passed this thing and it had not been told to the doctors of the state.

I would like to ask Dr. Foster or someone who is going to say whether these people can pay under this resolution that was adopted by the Council? Who is going to say whether they can pay this money or not? Whose judgment is it that they should get it from the State Lab free, or that we should send it to some commercial lab?

THE SPEAKER: Dr. Brosius, do you yield the floor?

W. L. BROSIUS, M.D.: Yes, I yield.

THE SECRETARY: Mr. Speaker, the action of The Council was based on a communication from the State Department of Health to The Council, in which they asked The Council's opinion as to whether or not they should make available for free Rh factor testing. They asked The Council for its opinion, and The Council rendered its opinion. So there was no occasion or mechanics at that time to publicize their opinion.

The State Department of Health sent a special communication to The Council. While there was no action taken on the determination of the economic status, I presume it was assumed to be determined like it is in all other cases, possibly by the family doctor himself or by someone who knows the family's economic status. The Council was not asked to determine it; they were simply asked to give an expression of what they thought should be done. It was their action that it be done by the state when there were no other facilities available on a private basis and to those people who could not afford to pay.

W. L. BROSIUS, M.D.: I would like to ask the House to vote on whether they think it is necessary that this House make a request of the State Laboratory that this service be continued. I would like to say—and I think I can speak for the pathologists—that they are as fully cognizant of the value of this test—certainly those of us who do autopsies know its value, as well as the obstetrician. The test should be done. It is simply a matter of policy and our requesting some state action which it may not be necessary to request.

S. W. INSLEY, M.D.: I apologize for speaking so many times, but I would like to point out that there have been a few statements made that do not follow out the matter whatever. Let's straighten the matter out. We can defeat this motion tonight without necessarily stopping the Boards of Health from continuing with this work.

The motion, as I see it, if it is passed, puts us deliberately on record as voting for one sector of medicine to be taken over as a state function. We can defeat this, but it does not stop these things from being done by the State Laboratory.

THE SPEAKER: May the Chair add, Dr. Insley, that this resolution says, "It is the urgent desire of this Society that this service be continued."

S. W. INSLEY, M.D.: We can defeat it, but it won't stop the tests being done. Let's keep our logic straight.

R. V. WALKER, M.D.: Mr. Speaker, I would like to ask one or two questions.

In the first place, is there a parallel between the two things Dr. Christian mentioned? We get the typhoid serum and vaccine. The private doctor uses those on his patients. Is it a service, not material, that we are asking the state to supply?

Again, how long will it be before some county comes in and asks that x-ray work be done gratis, and with the help of the state provide service for those people who supposedly cannot afford it?

The Rh factor is a necessity in the proper care of that type of work, but still why is it necessary to provide this type of service free to anyone for the asking? Pathologists are a part of us; they are a group of practicing physicians. Why aren't they entitled to the same respect in their specialty or in general practice as the rest of us?

L. G. CHRISTIAN, M.D.: May I answer Dr. Walker?

The Kahn test that you send to the lab—you don't use that. You haven't any material. That is a diagnostic service. The State of Michigan is certainly sending around their mobile units for x-ray work in the control of tuberculosis. This is another thing, a new affair. This is something that the average doctor does not know about. I am predicting that in ten years the doctor who does not do an Rh factor on every patient who comes into his office will not be doing good medicine. The same applied ten or fifteen years ago with doctors who didn't do a Kahn. We put on a program of syphilis detection in 1927 which was a marvel of the world. We were the first county society that knew and knows now the percentage of syphilis in that county. We want to do that again.

I am not against the pathologists, and I am not against anyone else on the State Board of Health. The State Department of Health laboratories did not offer this—we asked them for it. Just stop and think what this other doctor said! You fellows doing obstetrics have to take titers. You are going to lose women, you are going to lose babies, and it will make for better medicine, and that is what we are all talking about.

R. A. SPRINGER, M.D.: I don't think we need consider this at all. We are simply wasting a lot of time. The State Health Department is doing these tests and will continue to do them regardless of what action we may take at this time.

I see no reason why we should go on record requesting something which is already being done and which will continue to be done regardless of our action.

THE SPEAKER: Is there any further discussion?

H. H. RIECKER, M.D.: As a member of Dr. Breakey's Committee, your Committee took a rather broad viewpoint, in that this is a relatively new procedure, that no obstruction should be put in the way of any physician, and for the time being we should let this thing go along and let the state laboratory do the tests if they wish, or let any doctor send the bloods there for this procedure, since it is frequently life-saving, and we should not interfere with the service to any doctor in the state.

We took the broad viewpoint that for the time being, anywhere in the state, this should go on and we should not put any obstruction in the way of any doctor in the state to have this particular work carried out in any manner that can be done. That was the general impression of the Reference Committee's resolution.

THE SPEAKER: The resolution states, "It is the urgent desire of this Society that this service be continued." Is there any further discussion?

L. E. HOLLY, M.D. (Muskegon): I think we should have a resolution presented requesting the State Health Department to employ the services of a urologist to cystoscope all the patients, and they should provide the services of an obstetrician to do all the pre-natal care, and we should put all of these things on the state tax. They are capable of handling everything. Let's ask them for everything. They will get millions of dollars from the Federal government, so let's put everything on them. Why practice medicine?

L. J. BAILEY, M.D. (Wayne): I should like to propose a substitute motion, that the action of The Council be reaffirmed.

R. A. JOHNSON, M.D.: Second the motion.

THE SPEAKER: The motion is that the action of The Council be reaffirmed. The action of The Council, as stated by Dr. Foster, is that the recommendation is made to the State Health Department that these tests be performed in areas where they are not available on a private basis and to those who cannot afford to have them done in a private laboratory.

Is there any discussion on this substitute motion which will take the place of the original recommendation?

R. S. BREAKEY, M.D.: Mr. Speaker, I am sure I can speak for your Reference Committee in stating that the substitute motion would be acceptable. To facilitate the business of the evening, and to stop further unnecessary discussion, I personally feel, as a member of the House and not of the Committee, that if the House adopts the substitute motion we will stop much acrimony.

(The motion was put to a vote and was carried, but not unanimously.)

THE SPEAKER: Before the next resolution is presented the Chairman of the Reference Committee on Constitution and By-Laws has said that since the matter has been referred to them, and since it involves a proposal for an amendment to the By-Laws which must be presented one meeting before it is voted on, and since it is possible that the House is anxious to have a session during the winter next year, he would like to have me find out by a show of hands, just for his benefit because he wants to call his Committee together immediately if we are in favor, how many members of the House tonight are in favor of a session during the winter of next year, rather than waiting until September. May we have a show of hands of how many are in favor? Dr. Johnson, is that sufficient? It is a good three-fourths. Do you care to call that Committee meeting now?

VOICE: What about the "Noes?"

THE SPEAKER: The Reference Committee on Constitution and By-Laws will meet immediately in room 328.

Dr. Breakey, will you continue with the business?

XII—f. ON JMSMS

R. S. BREAKEY, M.D.: Resolution introduced by Dr. Owen of Wayne County:

"WHEREAS, the Michigan State Medical Society is one of the largest component state medical society units of the American Medical Association, and

"WHEREAS, there is considerable scientific medical work carried on in the State of Michigan at all times, and

"WHEREAS, if the Michigan State Medical Society had a first-class, up-to-date JOURNAL, with an aggressive scientific attitude it would be able to obtain an almost unlimited number of original articles from its own members, and

"WHEREAS, the quality of most of the scientific papers published in the Michigan State Medical Society JOURNAL is of a rather low level, consisting to a great extent of a re-hash of literature, and

"WHEREAS, some of the state medical society journals (e.g., the *New England Medical Journal*) in this country are of a very high caliber and publish considerable scientific work and numerous original articles; therefore, be it

"RESOLVED: By the House of Delegates of the Michigan State Medical Society at its meeting in 1947 in Grand Rapids, that aggressive action be taken by the Editorial Board and the business management of the JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY,

to place the JOURNAL in a position where the members who are doing high-grade scientific work will compete for space to publish their articles in the JOURNAL; and be it further

"RESOLVED: That there be no delay in the adoption of this new policy."

Your Committee discussed this resolution at some length, and felt that there were two alternatives: First, that the JOURNAL be an organ similar to its present structure in communication or advice to the numerous physicians in remote areas as to their interests locally and in the state; second, that it be an organ similar to the *Journal of the New England Medical Society*, as suggested.

The Committee felt the JOURNAL serves a useful purpose, advising physicians of Michigan on immediate and other medical problems, and on issues arising locally and throughout the state, and that scientific journals publishing original material were multiple and adequate to fill scientific requirements of physicians.

The Committee does not recommend the adoption of this resolution.

THE SPEAKER: The motion is that the House should not adopt this resolution.

R. S. BREAKEY, M.D.: The Committee does not recommend its adoption.

THE SPEAKER: Therefore, if we take action we will not recommend adoption; right? Is there a second?

HARRY LIEFFERS, M.D.: Second the motion.

W. I. CASSIDY, M.W. (Wayne): In view of the fact that the multiplicity of journals which we subscribe to today, and which two-thirds of us throw in the alley as far as anything new in them is concerned, except recapitulation and reorganization of the material—it is nothing but the old bunkum under new names—why in the world do we want to publish a Michigan State Medical JOURNAL dealing with a lot of guinea pigs, rabbits, cats and dogs?

The American Medical Association already has done that in their JOURNAL. You rarely see any article of value to the average fellow practicing medicine. You can read for hours and hours, and you don't know what they have done except on a few dogs and cats. What do they do for the humans? We ought to keep the JOURNAL for good, ordinary, commonsense practitioners, not for the boys to hit 'em on the head and show which way the lines of fractures went. Anyone knows which way they go! It's absolutely fundamentally useless. A fellow writes and writes and writes, and he does not say anything at the end of his writing except to bring out a little bunko which probably Napoleon did during the Napoleonic Wars. We're just going around in circles. Let's leave a little paper for some other Journals, and not use it all up!

Concerning this resolution, my advice is to stay right where you are. You have a pretty good JOURNAL. Let the eastern boys play with the hieroglyphics. Stay among the ordinary fellows. Don't get into the higher group where they are afraid to talk to each other. Stay with your feet on the ground and your shoulders in the air, and stick to the JOURNAL you have today. It has been built up throughout a period of years, and you'll be just as good doctors, if not better, if you continue doing as you are doing today.

THE SPEAKER: Is there any further discussion?

H. L. MORRIS, M.D. (Wayne): Mr. Chairman, I would like to take exception to what Dr. Cassidy said. I think there are a lot of clinicians in Michigan whose daily walks in life in the practice of medicine encounter a lot of situations which, evaluated, would be of value to all of us. I don't know that the clinical observations which we all make would be of outstanding value insofar as the world medical literature is concerned, but we as a group have something to contribute, and if we have no means of publicizing our contribution of our daily experiences I think we miss something that is of value to each and every one of us.

H. H. RIECKER, M.D.: I would like to go on record as saying that I don't know whether Dr. Cassidy is an authority on research of American medicine, but I would like to be recorded as saying that American research is pretty damned hot in the world as a whole, and we should not depreciate it. I favor rejection of this resolution, as suggested by the Committee, but I do want to defend American research in medicine.

F. H. DRUMMOND (Bay): We are always willing to accept articles if you send them in, but we have trouble getting them in. This resolution says the articles are "re-hashed." If that is true, what will we be here for during the next three days? At this year's Annual Session, we will have with us very brilliant men from all over the United States. It seems to me their work should be recognized.

THE SPEAKER: May I ask for a vote by a show of hands.

(The motion was put to a vote and was carried unanimously)

THE SPEAKER: It is obvious that some people speak louder than others. (Laughter)

XII—f. ON SPECIAL ASSESSMENT ($25)

R. S. BREAKEY, M.D.: Resolution submitted by Dr. Novy:

"WHEREAS, the standing of the medical profession demands a strong medical organization, and

"WHEREAS, a strong organization is dependent upon its financial ability to meet situations as they arise, and

"WHEREAS, we of Wayne County are fully aware of the need for a strong, well-armed medical organization; be it therefore

"RESOLVED: That an assessment of $25 for the year 1948 be levied, the same to be utilized at the discretion of the Council, in whom we have every confidence."

Your Committee felt that relative to the assessment of $25 for the year 1948 we would recommend the adoption of this resolution with certain amendments or changes. The following changes are made in the wording:

"RESOLVED: That an assessment of $25 for the year 1948 be levied upon each member, for the promotion of public relations and educational programs, the same to be utilized at the discretion of The Council, in whom we have every confidence."

The additional wording recommended by your Committee is to permit clarification and an explanation of the proposed use of these funds to individual members of the Society, and to avoid confusion.

The Committee felt as individual members that with this assessment (and we have had previous experience personally), our individual physicians requested information as to what use the $25 would be put to, and we lost five members last year because they didn't know whether they wanted to give the $25 or not; they didn't know what it would be used for.

The original wording, without change, gives no explanation; and it would appear to the average doctor of the State of Michigan to be ambiguous, and without any strings at all.

This is the resolution originally, as unamended:

"That an assessment of $25 for the year 1948 be levied, the same to be utilized at the discretion of The Council, in whom we have every confidence."

That really doesn't say it will be levied on anyone or anything. We have added, "upon each member for the promotion of public relations and educational programs."

Your Committee recommends the adoption of this resolution as amended.

H. W. WILEY, M.D.: Second the motion.

W. B. MITCHELL, M.D.: Just how many $25 are they going to ask for? The Council asks for a $25 assessment; Wayne County asks for a $25 assessment. Who should ask for this $25 assessment? I feel the report of The Council, as given last night, is where this $25 should be asked, and it will be reported back here when you ask for the report of the Reference Committee on The Council. I think the same $25 will be asked for.

THE SPEAKER: Dr. Mitchell, I think I can answer that.

W. B. MITCHELL, M.D.: This resolution means we are doubling it up.

THE SPEAKER: There was a resolution presented by Dr. Novy; that is true. The Council did recommend that a $25 assessment be made. The Public Relations Committee also has recommended that a $25 assessment be made. Therefore, those requests went to different committees. If it is passed once it will be passed for all. If it is turned down once on one resolution it may be passed under some other conditions when your Committee reports. However, if this is passed it will be necessary to make your recommendation.

W. B. MITCHELL, M.D.: Then what's the use of having special committee meetings here, and getting different opinions from two different committees?

THE SPEAKER: It might be of value. Dr. Mitchell, would you care to come up here and discuss what your Committee decided on this particular question?

R. S. BREAKEY, M.D.: Mr. Speaker, may I have the floor?

THE SPEAKER: Do you yield, Dr. Mitchell?

W. B. MITCHELL, M.D.: Yes.

R. S. BREAKEY, M.D.: I am in accord with what Dr. Mitchell said. This is confusing to me. Nevertheless, this is a resolution that was submitted on the floor of the House and referred to this Committee. I realize exactly that a similar question of expenditure was sent to your Committee. It was my impression that the two things were identical. I couldn't understand this, but I hope the House will appreciate that it was the obiligation of this Committee to report out this resoluion. Dr. Mitchell's question is an excellent one. There is a question of two $25 assessments. Either these are identical or it's fifty bucks. Isn't that right?

W. B. MITCHELL, M.D.: I think I had more at my Committee meeting than you did, and I think mine holds preference.

R. S. BREAKEY, M.D.: Mr. Speaker, the Reference Committee on Resolutions unanimously endorses Dr. Mitchell's suggestion that it be in his Committee's lap.

THE SPEAKER: Gentlemen, you have heard this resolution. I ask Dr. Mitchell if he cares to discuss this and to present the opinions given before his Committee, or whether he proposes any amendments to this resolution.

Do the delegates care to have the resolution re-read?

(Cries of "No!")

THE SPEAKER: Do you care to make any additional remarks, Dr. Mitchell?

W. B. MITCHELL, M.D.: I would rather not add any amendments or anything like that, other than to have this resolution removed from the table and have this placed in its stead.

E. D. SPALDING, M.D.: I move, Mr. Speaker, that this be tabled.

W. W. BABCOCK, M.D.: Second the motion.

(The motion to table the motion was put to a vote and was carried unanimously)

W. B. MITCHELL, M.D.: While this is fresh in the minds of the

assembly, with Dr. Breakey's permission I would like to present this at time, and have it over with.

R. S. Breakey, M.D.: Mr. Speaker, if it is not out of order, why not take it up and have it done?

XII—b. ON REPORT OF COUNCIL (Including $25 Assessment)

The Speaker: If there is no objection on the part of the House, we will ask Dr. Mitchell to present the report of his Committee on this one subject.

W. B. Mitchell, M.D.: This is all we have. This is the report of the Reference Committee on Reports of The Council.

"Substitute recommendation for Supplemental Recommendation No. 1: At a special meeting of the Committee on Reports of The Council, at 1 p.m. September 22, 1947, in Room 222, Pantlind Hotel, Grand Rapids, on motion and vote of the Committee, Supplemental Recommendation No. 1 of The Council's report was deleted and a substitute recommendation was made as follows:

"That the House of Delegates of the Michigan State Medical Society authorizes an assessment of $25 per capita membership, to be used at the discretion of The Council, for the continuation of an educational program, taking into consideration the recommendations of the Public Relations Committee. Further, that $30,000 or more of the money raised be added to the present reserve of $60,000; and further, that any or all of this reserve may be used as emergency dictates."

I move the adoption of this resolution.

Douglas Donald, M.D.: Second the motion.

P. L. Ledwidge, M.D. (Wayne): Who is to be judge of the "emergency"?

(Cries of "The Council!")

The Speaker: The Council. That is understood.

E. D. Spalding, M.D.: Mr. Speaker, in order that this may not work a hardship in certain special cases where dues are not paid by members in good standing, such as honorary members and residents and interns under some conditions, I would suggest that the assessment be applicable to dues-paying members. If those two words are inserted I think it will be fair all around.

The Speaker: That suggestion has been made. I believe it has been the interpretation of the Society that assessments are not paid by those who do not pay dues; is that right?

The Secretary: That is correct.

The Speaker: The wording is "per capita membership," or "authorized assessment of $25 per capita membership." Do you care to propose any amendments?

E. D. Spalding, M.D.: Would there be any objection to the words "to dues-paying members" being inserted?

The Speaker: Is there any objection on the part of the House? Do you care to propose that in the form of an amendment?

E. D. Spalding: If it will be helpful to the Chair, I so move.

The Speaker: The amendment is proposed that the words "dues-paying membership" be added.

E. C. Texter, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously)

Harry Lieffers, M.D.: Shouldn't that read "$30,000 or more?"

W. B. Mitchell, M.D.: That is how it does read.

(The motion as amended was then put to a vote and was carried unanimously)

W. B. Mitchell, M.D.: Mr. Speaker, I move that the report of the Reference Committee as a whole be adopted.

R. A. Springer, M.D.: I second the motion.

(The motion was put to a vote and was carried unanimously)

XII—f. FORMS OF MEDICAL PUBLIC RELATIONS

R. S. Breakey, M.D.: Resolution submitted by Dr. Krieg relative to the type of public relations publicity:

"WHEREAS, we recognize that the status of public relations has become an important aspect of medical practice, and

"WHEREAS, we realize that an adequate educative program can no longer be directed intelligently by the individual physician, and

"WHEREAS, it is extremely important to keep the tenure of such a program consistent with the dignity of time-honored relations between the patient and the physician, and

"WHEREAS, we find it extremely difficult and at times impossible to discuss 'Joe Genius' and the IDWTGTRMB Club at the same level with intimate medical care; be it therefore

"RESOLVED: That the Public Relations Committee be instructed to eliminate any and all such forms of adolescent approach to the public."

I move the adoption of this resolution.

L. J. Bailey, M.D.: Second.

(The motion was put to a vote and was carried unanimously)

XII—f. MHS RECOGNITION OF CERTAIN HOSPITALS

R. S. Breakey, M.D.: Resolution introduced by Dr. Livesay of Genesee:

"WHEREAS, the Michigan Hospital Service was created with the aid and approval of the doctors of medicine of the State of Michigan, and

"WHEREAS, the intimate association of the Michigan Hospital Service and the Michigan Medical Service has created the belief among the people of this state that they act for and with the consent of the doctors of medicine of Michigan, and

"WHEREAS, the Board of Directors of the Michigan Hospital Service are now recognizing certain substandard hospitals as participating in the Michigan Hospital Service plan, and

"WHEREAS, these substandard hospitals are not staffed by regularly registered doctors of medicine, and

"WHEREAS, the Michigan Hospital Service was organized to give the public a high quality hospital care during time of illness; therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society does regret, and protests, the action of the Board of Directors of the Michigan Hospital Service in recognizing those substandard hospitals, and requests that it reconsider its action with the view of discontinuing such recognition."

There was considerable debate and a rather long bearing before the Committee. The résumé of the feeling of your Committee is as follows:

Your Committee felt that action on this question is impossible, since the use of the definitive word "substandard" leaves the matter confused. It would be necessary to clearly define what must be considered "standard" hospitals in order to interpret the term "substandard." It was explained to the Committee that "substandard" was used as a qualifying term to avoid the use of "osteopathic" hospitals.

However, in many small communities all hospital services would be denied recognition by Michigan Hospital Service if the general term were permitted to stand. The sponsors of this resolution appreciated the fact that the resolution is ambiguous.

While the Committee endorsed the spirit behind the resolution, we do not recommend its adoption, and suggest it be resubmitted if desired.

I move that it be not adopted.

E. C. Texter, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously)

XII—f. MMS—ENABLING ACT

R. S. Breakey, M.D.: Resolution submitted by Dr. Livesay of Genesee relative to the fees to practitioners other than doctors of medicine by Michigan Medical Service:

"WHEREAS, Michigan Medical Service was created by the doctors of the State of Michigan, and was licensed under a special Enabling Act for the purpose of offering a high quality of prepaid medical service to the people of the State of Michigan, and

"WHEREAS, that quality of medical service is being endangered by the recognition and payment of fees to practitioners other than doctors of medicine, and

"WHEREAS, the Enabling Act No. 108, Public Acts of 1939, Section 12, paragraph 2, states, 'A non-profit medical care corporation shall not furnish medical care otherwise than through doctors of medicine (licensed and regulated under Act No. 237 of the Public Acts of 1899, as amended (No. 6737-6747),' and

"WHEREAS, the legality of such payments has never been passed upon by the Michigan Supreme Court; therefore, be it

"RESOLVED: That the elected and appointed officers of Michigan Medical Service be instructed to conform to the letter and spirit of the Enabling Act."

Your Reference Committee recommends that this be tabled, and I so move.

W. J. Cassidy, M.D.: Second the motion.

The Speaker: May I ask, just for the sake of keeping the

record straight, that Dr. Breakey reword his motion? It is not possible to table a motion which has not been made. If you make a request that no action be taken, I think we can vote on it. If you request to table a motion that has not been made, I think it is improper, and I don't believe the Chair can recognize it.

R. S. Breakey, M.D.: I don't wish to quarrel about technicalities. There is no motion on the resolution. There is no motion that it be adopted or not adopted. There is very definitely a motion that the resolution be tabled. That is a motion. The resolution was submitted, and the Committee unanimously moves that it be tabled. We will submit to a point of order.

The Speaker: Dr. Breakey, the Chair is unable to accept that motion. It is impossible to table a resolution which has been presented but on which no motion has been made. If you would make a motion that no action be taken on this resolution, I believe it would be a proper motion. It would amount to the same thing.

R. S. Breakey, M.D.: I will submit to the discretion of the Chair. I move that no action be taken.

The Speaker: Thank you.

T. Y. Ho, M.D.: Second the motion.

The Speaker: Before we vote I would like to ask Dr. Ledwidge: Do you feel this is a proper procedure?

P. L. Ledwidge, M.D.: I am not exactly a parliamentarian. I take it from the book. I think you're all right. Either one is all right in this particular case.

The Speaker: It is moved and seconded that no action be taken on this resolution.

C. L. Weston, M.D.: Mr. Chairman, I move that the motion be tabled.

W. J. Cassioy, M.D.: Second the motion.

The Speaker: There is no discussion on a motion to table.

(The motion to table was put to a vote and was carried, with one dissenting vote)

R. S. Breakey, M.D.: I should like to express my own appreciation to the Speaker for his excellent means of expediting this tedious report.

XII—f. MMS FEES TO OTHERS THAN DOCTORS OF MEDICINE

A resolution presented by Dr. Livesay of Genesee:

"WHEREAS, Michigan Medical Service was created by the doctors of Michigan for the purpose of supplying the best in prepayment medical service, and

"WHEREAS, certain members of the Board of Directors of Michigan Medical Service have appeared before The Council of the Michigan State Medical Society advocating a change in the Enabling Act, permitting the recognition and payment of fees to practitioners other than doctors of medicine, and

"WHEREAS, such a change is contrary to the content and spirit of the Enabling Act and contrary to the best interests of the medical welfare of the people of this State; therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society states as its established policy that the Enabling Act as now constituted, without any change at this time, will best serve the medical welfare of the people of the State of Michigan, and hereby directs its officers and representatives on the Board of Directors of Michigan Medical Service to act accordingly."

Your Committee was divided in its opinion as to this resolution. The majority of the Committee approved the adoption of this resolution. There is a minority report which I wish the Speaker would recognize prior to any discussion, because it is a minority report of the Committee and I personally am rather in accord with it.

To open the matter for discussion, I move the adoption of this resolution. Dr. Oakes will give the minority report.

L. W. Gerstner, M.D.: Second the motion.

The Speaker: If there is a minority report it will come up under discussion.

E. A. Oakes, M.D. (Manistee): If you will read the resolution carefully I think you will see that it is pointless. Two of us on the Committee agreed that the motion was pointless. It is already being complied with, and we see no reason to change the present procedure.

E. D. Spalding, M.D.: Mr. Speaker, I move that consideration of this resolution be indefinitely postponed.

H. J. Kullman, M.D. (Wayne): Second the motion.

(The motion was put to a vote and was carried unanimously)

The Speaker: Dr. Breakey, thank you.

R. S. Breakey, M.D.: I would like to move the adoption of the Reference Committee's report as a whole, as amended.

E. G. Krieg, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously)

The Speaker: Dr. Breakey should be thanked with his Committee for a long and arduous task.

XII—g. ON SPECIAL MEMBERSHIPS

The Speaker: Next is the report of the Reference Committee on Special Memberships. Dr. Harm.

W. B. Harm, M.D.:

"Whereas, the following members of the Michigan State Medical Society have been in the practice of medicine for at least fifty years, and

"Whereas, these members have been members in good standing of the Michigan State Medical Society for at least twenty-five years, and

"Whereas, these members have been accredited by the secretary of their respective county societies and the Secretary of the Michigan State Medical Society and recommended by their county societies; therefore, be it

"Resolved: That the following members of the Michigan State Medical Society be elected by the House of Delegates to Emeritus Membership in the Michigan State Medical Society:

NAME	CITY	COUNTY SOCIETY
J. M. JONES	Bay City	Bay-Arenac-Iosco
J. H. CHARTERS	Flint	Genesee
H. E. RANDALL	Flint	Genesee
L. J. BURCH	Mt. Pleasant	Gratiot-Isabella-Clare
B. C. HALL	Pompeii	Gratiot-Isabella-Clare
F. E. GRANT	Kalamazoo	Kalamazoo
E. P. WILBUR	Kalamazoo	Kalamazoo
A. S. YOUNGS	Kalamazoo	Kalamazoo
J. O. THOMAS	North Branch	Lapeer
DONALD MacINTYRE	Big Rapids	Mecosta-Osceola-Lake
L. K. PECK	Lake City	Mecosta-Osceola-Lake
L. I. POWERS	Muskegon	Muskegon
J. H. NICHOLSON	Hart	Oceana
L. P. MUNGER	Hart	Oceana
HENRY MEYER	Saginaw	Saginaw
W. B. BOPE	Decatur	Van Buren
J. H. ANDRIES	Detroit	Wayne
W. J. WILSON	Detroit	Wayne
HENRI BELANGER	Detroit	Wayne
L. J. HARRIS	Jackson	Jackson
G. E. WINTER	Jackson	Jackson
C. D. MUNRO	Jackson	Jackson

I move the adoption of this resolution.

J. J. O'Meara, M.D.: I second the motion.

(The motion was put to a vote and was carried unanimously)

(The Vice Speaker resumed the Chair)

W. B. Harm, M.D.:

"Whereas, the following members of the Michigan State Medical Society have all made application for Life Membership in the Michigan State Medical Society, and

"Whereas, these members have reached the age of seventy years and have been members of the Michigan State Medical Society at least ten years, and

"Whereas, these members have been so accredited by their respective county society secretaries, the Secretary of the Michigan State Medical Society, and recommended by their county societies; therefore, be it

"Resolved: That the following members of the Michigan State Medical Society be elected by the House of Delegates to Life Membership in the Michigan State Medical Society:

NAME	CITY	COUNTY SOCIETY
J. W. GAUNTLETT	Traverse City	Grand Traverse-Leelanau-Benzie
C. A. CARPENTER	Onaway	Alpena-Alcona-Presque Isle
G. C. KELLER	Hastings	Barry
NINA ELY	Bay City	Bay-Arenac-Iosco
J. C. GROSJEAN	Bay City	Bay-Arenac-Iosco
E. C. HUGHES	Bay City	Bay-Arenac-Iosco
J. A. KEHO	Bay City	Bay-Arenac-Iosco
G. W. MOORE	Bay City	Bay-Arenac-Iosco
E. A. WITTWER	Bay City	Bay-Arenac-Iosco
C. S. GORSLINE	Battle Creek	Calhoun
LYDIA JESPERSON	Battle Creek	Calhoun
A. E. MacGREGOR	Battle Creek	Calhoun
B. L. SELMON	Battle Creek	Calhoun
W. V. VANDERVOORT	Battle Creek	Calhoun
ELIJAH VanCAMP	Battle Creek	Calhoun
R. C. WINSLOW	Battle Creek	Calhoun
C. D. HUBER	Charlotte	Eaton
M. E. CHANDLER	Flint	Genesee
E. B. GUILE	Flint	Genesee
A. W. HARPER	Flint	Genesee
G. W. LOGAN	Flushing	Genesee
W. H. MARSHALL	Flint	Genesee
L. L. WILLOUGHBY	Flint	Genesee
W. H. WINCHESTER	Flint	Genesee
DAVID TREAT	Flint	Genesee
C. H. PEABODY	Lake Odessa	Ionia-Montcalm
E. R. SWIFT	Lakeview	Ionia-Montcalm
D. J. MONROE	Elkton	Huron
W. A. COCHRANE	Jackson	Jackson
F. J. GIBSON	Jackson	Jackson
G. R. PRAY	Jackson	Jackson
N. D. WILSON	Jackson	Jackson
W. F. ERTELL	Kalamazoo	Kalamazoo
C. B. FULKERSON	Kalamazoo	Kalamazoo
THOMAS VanURK	Kalamazoo	Kalamazoo
C. N. BOTTUM	Marquette	Marquette-Alger
PAUL VanRIPER	Champion	Marquette-Alger

NAME	CITY	COUNTY SOCIETY
W. G. HUTCHINSON	Pontiac	Oakland
W. J. PRESLEY	Grand Haven	Ottawa
W. H. BROCK	Saginaw	Saginaw
J. A. McLANDRESS	Saginaw	Saginaw
F. B. ASHTON	Detroit	Wayne
E. F. DAVIS	Detroit	Wayne
C. A. FETTIG	Detroit	Wayne
J. A. FREESE	Detroit	Wayne
C. W. KNAGGS	Detroit	Wayne
J. B. MORIN	Detroit	Wayne

W. B. Harm, M.D.: I move the adoption of the resolution.

George Waters, M. D. (St. Clair): Second.

(The motion was put to a vote and was carried unanimously)

W. B. Harm, M.D.:

"Whereas, the following physicians have been recommended by their respective county society for good reason; therefore, be it

"Resolved: That the following physicians be elected by the House of Delegates to Associate Membership in the Michigan State Medical Society:

NAME	CITY	COUNTY SOCIETY
W. S. CHAPIN	Muskegon	Muskegon
FRED REETZ	Shelby	Oceana
O. M. LaCORE	Muskegon	Muskegon
J. C. KENNING	Beverly Hills, Cal.	Wayne
J. L. BOYD	Muskegon	Muskegon
D. J. REDNER	Howell	Livingston

I move the adoption of the resolution.

W. J. Cassidy, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously)

W. B. Harm, M.D.:

"Whereas, the following member of the Michigan State Medical Society has retired from the active practice of medicine for good reasons, and

"Whereas, this member has been recommended by his county medical society and accredited as having been a member in good standing for at least ten years by his respective county secretary and the Secretary of the Michigan State Medical Society; therefore, be it

"Resolved: That the following active member of the Michigan State Medical Society be transferred to retired membership in the Michigan State Medical Society:

NAME	CITY	COUNTY SOCIETY
H. R. WILSON	Saginaw	Saginaw

I move the adoption of the resolution.

Douglas Donald, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously)

W. B. Harm, M.D.: There was some difficulty and misunderstanding this year because the method of presenting these various memberships to the delegates has been changed this year. Late this evening we received an application for Life Membership from Dr. N. J. Robbins of Negaunee. Dr. Robbins was continuously a member up to and including 1945. As he was then past seventy years of age, his name should have been presented that year. For the past year he has not been active. The County Society would like to honor him with a Life Membership.

Your Committee, according to the Constitution and By-Laws, could not present him with this Life Membership because he has been practically a suspended member of the State Society for the last two years, not having paid his dues. At the request of the representative of the Marquette-Alger County Society we are presenting his name for your pleasure.

R. A. Springer, M.D.: I move that he be granted the honor of Life Membership.

W. S. Jones, M.D.: (Menominee) I second the motion.

(The motion was put to a vote and was carried unanimously)

The Vice Speaker: Dr. Robbins' name will be added.

W. B. Harm, M.D.: Mr. Chairman, I move the adoption of the report of the Reference Committee as a whole.

R. A. Springer, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously)

The Vice Speaker: The next order of business is unfinished business.

XII—c. ON SEMI-ANNUAL MEETING OF HOUSE OF DELEGATES

R. A. Johnson, M.D.: The Committee on Amendments to the Constitution and By-Laws has met and desires to submit the following:

To amend Chapter 3, Section 1 on page 121 of the Handbook by inserting, after the word "annually," the words "in the last six months of the year," and after the word "session" the following words: "and semi-annually during the first six months of the year, at such time and place as the Executive Committee of The Council shall determine."

The amended section will read as follows: "The House of Delegates shall meet annually in the last six months of the year, at the time and place of the annual session, and semi-annually during the first six months of the year, at such time and place as the Executive Committee of The Council shall determine, and may hold such numbers of meetings as the House may determine or its business require, adjourning from day to day as may be necessary to complete its business, and specifying its own time for the holding of its meetings."

(The speaker resumed the Chair)

The Speaker: This amendment will come up automatically for vote in the meeting tomorrow.

Dr. Sladek, do you have a supplemental report of The Council?

V. SUPPLEMENTAL REPORT OF THE COUNCIL ON STUDY OF MEDICAL PRACTICE ACT

E. F. Sladek, M.D.: This is a supplemental report of The Council, given to you just as a matter of information.

There has been some discussion relative to the action of a committee of The Council. This is the committee to study the Medical Practice Act, of which Dr. Harold Morris is Chairman. This is a Committee of The Council, a fact-finding Committee. Its work is not completed, but when it has a definite recommendation to make it will be given to the membership through the proper channel. It is hoped that this recommendation or the action of this Committee or the report of this Committee will be given to The Council at the next Secretaries' Conference in January.

The Committee is exploring the possibility of changing the Medical Practice Act, with a view toward solving the general problems of all the healing arts. You will get information on this later.

The Speaker: Thank you, Dr. Sladek. This is a supplemental report of The Council, and as such will be referred to the Reference Committee on Reports of The Council. Is that the way it was meant?

Is there any further unfinished business to come before the House, other than the reports of Reference Committees?

If not, is there any new business?

VIII—r. DEFINITION OF MEDICAL SERVICES IN MHS CONTRACTS

R. J. Armstrong, M.D. (Kalamazoo): I have a resolution, Mr. Speaker:

"Whereas, the services of the pathologist, roentgenologist, anesthesiologist and physical therapist are medical services, and

"Whereas, Michigan Hospital Service wrongfully offers two of these services (pathology and anesthesiology) to the public as benefits under hospitalization insurance policies, and

"Whereas, Michigan Hospital Service, the Blue Cross plan covering the State of Michigan, has failed to discontinue this practice and has in fact encouraged the practice of one of these specialties (anesthesiology) by laymen, and

"Whereas, the House of Delegates of the American Medical Association has gone on record as strongly disapproving this practice of encroachment; therefore, be it

"Resolved: That the Medical Society of the State of Michigan, through its House of Delegates, reaffirm its disapproval of this practice; and be it further

"Resolved: That this House of Delegates instruct our representatives on the Board of Trustees of the Michigan Hospital Service to oppose this encroachment on the private practice of medicine; and be it further

"Resolved: That the Secretary of the Michigan State Medical Society be instructed to notify each county medical society of this action, and advise the medical boards and individual members thereof of the importance of establishing in their hospitals the principle that the practice of pathology, roentgenology, anesthesiology and physical therapy is the practice of medicine and not a hospital service; and that the Hospital Board of Directors be asked to discontinue the inclusion of these medical services in any contract for hospital service."

The Speaker: This resolution will be referred to the Reference Committee on Resolutions.

Is there any other new business?

VIII—s. ON BASIC SCIENCE LAW

M. A. Darling, M.D.: I have a resolution:

"Whereas, the basic science law or Public Act No. 69, designed to regulate the practice of healing in the State of Michigan and to provide for examination in basic sciences as a prerequisite to eligibility to practice the art of healing in this State, has now had a trial period of several years, and

"Whereas, the theory upon which this law was enacted was that it would raise the standards of medical practice in this State; and

"Whereas, this law has proved to be an insurmountable barrier to all medical graduates from outside the State of Michigan, and

"Whereas, experience has shown that the results obtained have not confirmed the theory upon which the law was enacted; and that the rigid examinations exclude from certification practically all candidates for licensure with the exception of those examined immediately following the basic science years in medical school, and

"Whereas, the hospitals in Michigan which offer approved residency training in the various specialties have been and will continue to be avoided, because of this law, by medical graduates from other states who have excellent scholastic and internship records; and

"Whereas, the long waiting period necessitated by the examinations, the expense of travel and fees, the uncertainty of certification, and the weeks of review of all subjects obviously influence these men to accept an appointment in some other state; and

"Whereas, the educational opportunities for postgraduate training at the medical centers and in hospitals in this State are not available to all applicants for such training because of the stringent requirements of this law; and

"WHEREAS, for the intent and purpose of protecting the health and welfare of the people of this State it is desirable that medical graduates who show promise of leadership be attracted instead of repelled from this State; and

"WHEREAS, medical licensure by reciprocity with other states is nullified by the existing basic science law; and

"WHEREAS, the basic science law is a detriment to the future of good medical practice in this State, impedes postgraduate training, and deprives the hospitals of the services of the best among applicants for resident training; therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society urge that this law be repealed and a substitute bill introduced to remove the objectionable features of the present law."

Mr. Speaker, I am presenting this resolution at the request of the Washtenaw County Medical Society, and it is signed by Dr. Donaldson as Chairman of the Basic Science Committee of the Washtenaw County Medical Society and has the approval of Dean A. C. Furstenburg.

THE SPEAKER: This will be referred to the Reference Committee on Resolutions.

H. J. KULLMAN, M.D. (Wayne): I do not have a resolution. I wish to speak and have some consideration given to this particular subject and, if this body so desires, appoint a committee for the study of same.

It concerns new membership. I am not impressed with the increase in membership, neither in the county medical societies nor the State Medical Society.

I raise the question of whether the $25 assessment has anything to do with returned members of the armed forces having to join their constituent societies and the State Medical Society. I also raise the question of whether we are getting our new membership among the recent graduates. The figures on the present membership of the State Society are not impressive as compared to what existed prior to the war.

Therefore, I should like to suggest to this body that some study be given this particular subject, as to whether we are encouraging or discouraging membership in organized medicine.

THE SPEAKER: Do you care to make any motion?

H. J. KULLMAN, M.D.: I do not.

THE SPEAKER: If this is a suggestion, the Chair will see to it that the suggestion is carried to the Chairman of The Council for study, if there is no objection to that procedure.

H. H. RIECKER, M.D.: Mr. Speaker, we have that problem at the university in Ann Arbor with younger men who have to belong to the County Society in order to be admitted to their specialty board examinations. We have solved it by making them associate members at a nominal fee. Apparently that is going through all right with the specialty boards.

It has rather solved the problem of the young residents in training who want to take a specialty course but have to belong to the American Medical Association. We make them associate members. Possibly this will be a contribution to the doctor's suggestion about membership.

THE SPEAKER: Thank you. Is there any other new business to come before the House? If not, is there a supplemental report from the Reference Committee on Officers' Reports? Reference Committee on Reports of The Council? Reference Committee on Reports of Standing Committees? Reference Committee on Reports of Special Committees?

XII—d. ANNUAL REPORT OF COMMISSION ON HEALTH CARE

L. W. GERSTNER, M.D.: This is a supplemental report of the Reference Committee on Report of the Commission on Health Care.

We move that the report be accepted, and Dr. Pino be thanked for the vast amount of work he and his Committee have done. We move also that the Commission be continued and the program be supported.

I move its adoption.

THE SPEAKER: It is moved that the report of the Commission on Health Care be accepted and their work approved and continued

R. L. WADE, M.D.: I second the motion.

(The motion was put to a vote and was carried unanimously)

THE SPEAKER: Is there a supplemental report from the Reference Committee on Special Memberships? Reference Committee on Resolutions? Is there any further business to come before the House?

XII—c. ON PUBLIC RELATIONS

WILLIAM BROMME, M.D.: Mr. Speaker, I wish to present the final supplemental report of the Committee on Reports of Standing Committees. One section was deleted from the consideration of the entire group of sixteen this morning.

The Committee recommends the adoption of the report of the Public Relations Committee for the year 1946-47. Previous sections of comment have been deleted from this final supplemental report.

I move, Mr. Speaker, the adoption of the report of the Public Relations Committee for the year 1946-47. This was the Reference Committee on Reports of the Committee for 1946-47 as published in the Handbook.

THE SPEAKER: You don't mean last year's report?

WILLIAM BROMME, M.D.: 1946-47. It was referred to us for study. We have no projected future program.

THE SPEAKER: It is moved that the report of the Reference Committee on Standing Committees, as far as it applies to the report of the Public Relations Committee, be adopted.

R. S. BREAKEY, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously)

WILLIAM BROMME, M.D.: I believe there is no further motion necessary to clear the entire report. I move you, Mr. Speaker, that the report of the Reference Committee on Reports of Standing Committees for the year 1946-47 be accepted in toto.

T. Y. HO, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously)

THE SPEAKER: Is there any other business to come before the House?

XII—e. PROPOSED AMENDMENTS TO CONSTITUTION FROM 1946

R. S. BREAKEY, M.D.: I should like to move, Mr. Speaker, a reconsideration of a matter which was closed, I believe, in haste this morning, and that is the requirements for life membership in this Society. I do this because I have heard much personal expression of opinion and regret that this requirement was worded so that a man who has attained the age of seventy, and who has been a member of this Society for twenty-five years, may apply through his county society.

I appeal to you: How does one apply for an honor? I think there are too many of our respected men of long and outstanding service whom we are slapping in the face because their pride won't let them apply.

Mr. Speaker, I move that this question of life membership be brought on the floor for reconsideration.

W. J. CASSIDY, M.D.: I second the motion.

THE SPEAKER: Dr. Breakey, did you vote for the amendment to the Constitution this morning, or against it? This motion can be made only by one who voted in favor of it.

R. S. BREAKEY, M.D.: As a matter of fact, I suppose I voted for the approval of the Committee report as a whole, which involved endorsement—

THE SPEAKER: You voted on the amendment?

R. S. BREAKEY, M.D.: I did.

THE SPEAKER: Your motion is in order. However, this is an amendment to the Constitution and was adopted by a two-thirds vote. The question before the House is whether we shall reconsider the amendment to the Constitution which was passed this morning. The matter is open for debate.

Is there any discussion on the matter of whether we shall reconsider the amendment to the Constitution affecting life membership?

T. K. GRUBER, M.D.: On page 117, Amendments to the Constitution, Section 2: "This Constitution shall become effective immediately upon its adoption." It will require another amendment to change it. It became effective immediately upon adoption this morning. If you want to have an amendment, that is all right. I agree with your idea.

R. S. BREAKEY, M.D.: Mr. Speaker, I grant this is an amendment to the Constitution, but this is a single session of this House. It is an interrupted session, but a single session. If we are speaking about parliamentary order, action is not taken until this session is closed. We can move for reconsideration.

T. K. GRUBER, M.D.: It says "shall become effective immediately upon adoption."

THE SPEAKER: Gentlemen, according to Robert's Rules of Order a motion may be reconsidered if it is proposed by one who has voted for that motion, and it can be reconsidered during that meeting or during an immediately subsequent meeting; according to Robert's Rules of Order, also, action cannot be reversed. In other words, if action has followed the passage of this motion or amendment which cannot be reversed, it would be out of order. However, if no action has taken place since the adoption of the motion or the amendment which makes it impossible to reverse the action of the motion or amendment, it would be in order. Therefore, the Chair would have to rule that this motion to reconsider is in order.

The Chair will declare that the motion to reconsider is now before the House, to reconsider the vote we took this morning on the amendment concerning life membership.

Is there any further discussion?

R. S. BREAKEY, M.D.: May I move that this question be referred back to the Committee of reference, in order that they may consider means of expediting or clarifying the honorary position of life membership, without requiring the individual to take any action whatsoever.

THE SPEAKER: Dr. Breakey, I do not believe we can refer this matter until we decide to reconsider it. It is up to the House to decide whether we care to reconsider this action or not.

R. S. BREAKEY, M.D.: We voted to do so, Mr. Speaker.

THE SPEAKER: We have not voted to reconsider this action.

R. S. BREAKEY, M.D.: I beg your pardon.

THE SPEAKER: The question now before the House is whether we will reconsider our action of this morning.

R. S. BREAKEY, M.D.: I *was* out of order!

R. A. JOHNSON, M.D.: There is absolutely no intent to degrade by asking a man to make a signed application for transfer to the life membership roster. There is a variety of memberships. There is a place for an individual who is past the active phase and who is not eligible for the emeritus phase, to have the privileges of life membership. How are we best to know who those men are?

You and I all know individuals who prefer to continue as active members when they are eligible for life membership. If the individual himself wants life membership, he is entitled to have it. That is why we ask for his signed application. It is a favor to him. I don't see that he is asking for an honor. He is asking for a concession.

THE SPEAKER: Is there any further discussion on the motion to reconsider?

C. S. CLARKE, M.D.: As a member of the Committee on Special Memberships, and also as a proposer of a list of four names for life membership, this matter was discussed among the

members of our delegation here, and I think we feel a life membership should not be thrust upon a person; neither do we want to give life memberships to people who are still active and who don't care for them. If that were worded in such a way "with the okay of the man who is to have the life membership," or something like that, it would settle it. It could be proposed by the secretary of the county society or by the society through the secretary, but I think it should be with the permission rather than upon the request of the member involved.

THE SPEAKER: Is there any further discussion on the motion to reconsider?

L. W. DAY, M.D. (Hillsdale): This can all be settled on page 113, Section 6: "Any physician who has been in practice for fifty years and has maintained a membership in good standing for twenty-five years may, upon application and recommendation of his county society." Not upon application by the individual, but by application of the county society. So the individual does not have to request his own honorary membership.

THE SPEAKER: It has been pointed out that is emeritus membership, Dr. Day.

L. W. DAY, M.D.: It says the same thing under life membership, too.

R. S. BREAKEY, M.D.: Mr. Speaker, that is not pertinent to what was passed this morning.

THE SPEAKER: Are you raising a point of order?

R. S. BREAKEY, M.D.: I am merely answering Dr. Day. The matter passed this morning was a revision of the Constitution, and this does not apply. What I wish reconsidered is not what is here, but what was done this morning. It is still not in print. It is a matter of the reporter's record, that's all.

R. V. WALKER, M.D.: It isn't the idea of thrusting life membership upon a man who has reached that age. Isn't a man of that age, who has been a member in good standing for twenty-five years, entitled to that recognition? If the county society asks him to sign the application, it is a matter of his applying for it after all. Isn't it an honor to be given to him in recognition of his services, without his applying for it?

R. A. JOHNSON, M.D.: May I answer that? There is a confusion about this matter that is unnecessary. Individuals can be eligible for life membership and can prefer to stay as active members. We honor them for that preference. Why compel a man, because he has attained the age of seventy and been in practice for twenty-five years, to automatically become a life member? That is wrong. If he wants to continue as an active member he has that right. If he prefers to become a life member, it is his selection. It is a concession that this Society wants to give him. What's wrong about that?

R. S. BREAKEY, M.D.: Dr. Johnson, I am in accord with what you said. However, if a man wishes to continue an active member there is no reason why he may not do so. He can be 102 years of age. My grandfather was an active member of his society until he was seventy-eight. However, there are a number of individuals among us today who will be required to sign an application, by what we passed today. This is a means of implementing life membership, not requiring it.

R. A. JOHNSON, M.D.: Why do they hate to sign it? What's wrong about signing it?

R. S. BREAKEY, M.D.: When I am seventy years old I will have been in practice of medicine well over twenty-five years, and a member of this Society for longer than that, and I will not desire to sign a petition granting me life membership if this group gives me life membership and some recognition of long-standing service.

R. A. JOHNSON, M.D.: How are they going to know you want life membership?

R. S. BREAKEY, M.D.: I can refuse it. That is my privilege.

THE SPEAKER: Any further discussion on the motion to reconsider?

L. J. BAILEY, M.D.: This question came up in Wayne County, and it was brought to our attention that on certain occasions when men were reminded that they were eligible for life membership the State Society was not too pleased that they were so reminded.

Furthermore, Dr. Breakey's points are very well taken, because in spite of many of the points brought up here tonight, a man loses no privileges in the Society except the privilege of paying dues. That was the reason why the State Society didn't care, a lot of times, that the county society reminded men of their eligibility.

R. H. DENHAM, M.D.: Mr. Chairman, I spoke to this point yesterday when the question came up. Kent County has presented the names of a number of their members who are well past seventy, for life membership. Not one of them would ever have applied for that life membership. The County Society asked them first. We felt we were honoring those men. Among those who were past seventy or seventy-five there were three or four who did not desire it, and it was not thrust upon them under our old arrangement.

I feel it is not incumbent upon the man who is past seventy to go begging for a life membership. If he desires it or if he accepts it, he should have it out of respect to his age and years in practice.

I feel rather strongly about that. I don't believe many members would ever sign that petition for life membership if they respected themselves.

H. G. HUNTINGTON, M.D. (Livingston): This could be settled very easily by inserting the word "or" after the word "and." "Application and/or recommendation."

THE SPEAKER: Dr. Huntington, we passed an amendment this morning to the Constitution on this matter. We are not voting on what is in the Handbook now. I don't believe the wording in the book applies at the present time.

H. G. HUNTINGTON, M.D.: Why can't we just change the wording enough so they can apply if they want to, or it can be offered by their county society?

THE SPEAKER: Gentlemen, we are supposed to be discussing whether we want to reconsider this matter or not.

(The motion to reconsider was put to a vote and was carried, but not unanimously)

THE SPEAKER: The motion is passed; therefore, the next matter of business is the discussion of the amendment which is now being reconsidered—the amendment on life membership. Is there any discussion?

R. S. BREAKEY, M.D.: I should like to say just what I said before, when I was out of order: I move that this be referred back to the Committee of reference for reconsideration, with the instructions from the House that all requirements as to application on the part of such individuals as may be eligible be deleted.

W. J. CASSIDY, M.D.: Second the motion.

THE SPEAKER: You have heard the motion that the amendment be referred back to the Reference Committee on Constitution and By-Laws for reconsideration, with those recommendations, and to be reported out tomorrow morning.

T. K. GRUBER, M.D.: I don't believe it is necessary for all that if Dr. Breakey will state his amendment or change it now. He can state it right here and we won't have to refer it to anybody.

THE SPEAKER: There is a motion to refer it back to Committee —unless Dr. Breakey cares to withdraw his motion?

GEORGE WATERS, M.D.: I am rather peeved at you young fellows worrying about some of us older fellows. Personally, I am eligible for life membership, but I want no life membership as long as I am active in the practice of medicine and can take care of my own Society dues.

I think possibly I am expressing the opinion of all those older men. They do not want anything forced on them. If a man has arrived at the point where he is unable to continue with his practice, then give it to him. Or, if he declares his intention that he would like it, give it to him. That can very well be taken care of without any of this legislation. The Secretary of the Society knows those people, and if there is any man who is eligible it won't do any harm for the Secretary to ask him if he would like to have his name presented.

I think we are making a big fuss over nothing. The old regulation was very good. You haven't heard a word from any of us older fellows. I want to tell you that I don't consider myself old, either! (Applause)

L. W. GERSTNER, M.D.: Could we have the motion read that was given this morning?

THE SPEAKER: For that express purpose I asked Dr. Johnson to come up here and tell us. He hasn't the motion—it isn't in the room—but he can tell us the exact wording.

R. A. JOHNSON, M.D.: Page 113, Section 8, Life Members. This morning it was amended to read as follows:

"A physician who has attained the age of seventy years or more, and maintained an active membership in good standing for twenty-five years or more, and upon his personally signed application and recommendation of his county society, may be transferred to life member roster by election of the House of Delegates. He shall have the right to vote and hold office, but shall pay no dues to the State Society. Request for transfer should be accompanied by certification by the Secretary of the Society as to the years of membership in good standing."

If I may add a word on my own, I see no need to refer this back to the Reference Committee if the objection to "his personally signed application" is the only part of this amendment that is causing trouble. That can be deleted by action of the House. If Dr. Breakey will withdraw his motion—

R. S. BREAKEY, M.D.: Dr. Johnson, I shall be glad to withdraw that motion and substitute a motion—

THE SPEAKER: Just a minute. Who seconded the motion? Dr. Cassidy, are you willing to have the motion withdrawn? It is withdrawn and we are ready for another motion.

R. A. JOHNSON, M.D.: I feel it would be better if the motion came from me as Chairman of the Reference Committee.

R. S. BREAKEY, M.D.: I certainly will gracefully accept that.

R. A. JOHNSON, M.D.: I move that the phrase "his personally signed" be deleted from the amendment as read.

R. S. BREAKEY, M.D.: I support it.

THE SPEAKER: It is moved and supported by Dr. Breakey that the words "his personally signed" be deleted from the amendment applying to life membership. Is there any discussion?

R. S. BREAKEY, M.D.: Just a minute. "His personally signed application."

THE SPEAKER: The word "application" will stay in.

R. S. BREAKEY, M.D.: I don't think he should have to make application. You are in accord with what I am thinking, Dr. Johnson, and what all the men I talked to this morning said. His county society can say, "Doctor, would you like to be a life member or not? You won't have to sign and apply."

R. A. JOHNSON, M.D.: If the motion that I just made holds, the reading of the amended section will be as follows:

"Section 8, Life Members: A physician who has attained the age of seventy years or more, and maintained active membership in good standing for twenty-five years or more in the State Society, may, upon application and recommendation of his county society, be transferred to the life membership roster," and so on.

R. S. BREAKEY, M.D.: That is okay.

L. J. BAILEY, M.D.: That has been interpreted by some county societies to mean that they may not notify a man of his eligibility.

E. D. SPALDING, M.D.: One more thing, Mr. Speaker: We all understand what is meant by this now, but five years from now the House of Delegates may not understand, and the difficulty will arise because the words "application" and "recommendation" may not necessarily apply to the county society. One may apply it to the man, saying that is an application by the man and a recommendation by the county society.

If that sentence were reworded so that the county society would come first and the words "application and recommendation" follow the words "county society," there would be no question.

THE SPEAKER: Do you care to propose an amendment to the amendment to reword it?

E. D. Spalding,, M.D.: I would rather leave it in the hands of the Chairman of the Committee who offered the recommendation. I think a moment's pencil work on his part will remove this objection.

The Speaker: Dr. Johnson, will you take the floor again? Do you care to reword your proposed amendment?

R. A. Johnson, M.D.: Just a moment.

The Speaker: The question before the House now is an amendment to strike out the words "his personally signed" before the word "application." Gentlemen, if we can stay in session and settle this tonight it will save us a good deal of time tomorrow morning.

R. H. Denham, M.D.: Does that mean the application of the individual or the application of the county society?

The Speaker: I take it it means not his personally signed application—

R. H. Denham, M.D.: Does it mean his application?

The Speaker: His application from the secretary of the county medical society. However, if we can wait for just one moment maybe Dr. Spalding and Dr. Johnson can settle it.

S. L. Loupee, M.D.: If nobody has the floor I would like to talk a moment. I would like to get rid of two words and then adjourn.

Why have those words "upon application"? They are not needed. ". . . and may, upon recommendation of his county society . . ." is all that is needed.

R. A. Johnson, M.D.: May I make that my motion? I should like to incorporate that phraseology in my motion, which deletes "his personally signed."

The Speaker: Dr. Johnson, then you would please be kind enough to word the sentence now, so we will all understand it.

R. A. Johnson, M.D.: "A physician who has attained the age of seventy years or more, and maintained an active membership in good standing for twenty-five years or more, upon recommendation of his county society may be transferred to life member roster by election of the House of Delegates," and so on.

S. L. Loupee, M.D.: That solves the application.

The Speaker: Do you support that, Dr. Loupee?

S. L. Loupee, M.D.: Yes.

The Speaker: It was a little irregular, but we are all agreed on this wording. Is there any further discussion on this proposed amendment?

C. S. Clarke, M.D.: Again I want to call your attention to the fact that you do not take under consideration the fact that you must have the consent of the man whose recommendation goes in. Five years from now, as Dr. Spalding said, some county society will say, "Here are a lot of our fellows who are seventy years old; let's put them all in."

(The question was called for; the motion was put to a vote and was carried unanimously)

The Speaker: The amendment is passed. The business before the House is a vote on the original amendment to the Constitution, as proposed this morning and as amended just now. Is there any discussion on the original amendment as it was worded this morning and amended this evening?

(The amendment was put to a vote and was carried unanimously)

The Speaker: Is there any further business to come before the House? If not, gentlemen, may I remind you that tomorrow we must close in time for the scientific session at noon. God only knows what will come up at the last session, so I urge you to be here at eight o'clock sharp. Thank you for your co-operation this evening. The meeting is recessed.

(The meeting recessed at 10:45 p.m.)

Fourth Meeting

Tuesday Morning, September 22, 1947

The meeting convened at 9 a.m., Dr. J. S. DeTar, Speaker of the House of Delegates, presiding.

The Speaker: The House will please come to order.

May we have the report of the Credentials Committee?

J. J. O'Meara, M.D.: Mr. Speaker, I wish to state that my Committee has collected eighty-two applications. This, of course, is more than 40 per cent, which is a quorum, 50 per cent of which are not from any one county.

The Speaker: Thank you, Dr. O'Meara. This will be considered as the roll call.

The next order of business is unfinished business. Is there any unfinished business to come before the Society at this time? Is there a supplemental report of The Council, Dr. Sladek?

E. F. Sladek, M.D.: There is not, Mr. Speaker.

The Speaker: The reference committees will be given an opportunity to make their supplemental reports. Is there any supplemental report from the Reference Committee on Officers' Reports? Standing Committees? Special Committees? Constitution and By-Laws?

XII—c. ON SEMIANNUAL MEETINGS OF HOUSE OF DELEGATES

R. A. Johnson, M.D.: To amend Chapter 3, Section 1 by inserting after the word "annually" the words "in the last six months of the year," and after the word "session" the following words, "and semi-annually during the first six months of the year, at such time and place as the Executive Committee of The Council shall determine."

The amended Section 1 will read as follows: "The House of Delegates shall meet annually in the last six months of the year, at the time and place of the Annual Session, and semi-annually during the first six months of the year, at such time and place as the Executive Committee of The Council shall determine, and may hold such number of meetings as the House may determine or its business require, adjourning from day to day as may be necessary to complete its business, and specifying its own time to the holding of its meetings."

I move the adoption of this amendment to the By-Laws.

J. E. Livesay, M.D.: Second the motion.

The Speaker: This provides for an annual meeting in the fall and a meeting semi-annually in the spring.

L. W. Gerstner, M.D.: I would question the need of incorporating that in the By-Laws, inasmuch as we have a mechanism set up whereby, if a meeting is desirable, a special meeting may be called. I wonder if a member of The Council would discuss from The Council's angle the need for implementing this meeting with another earlier in the year.

The Speaker: A request has been made for a member of The Council to discuss this matter. Does any member of The Council care to discuss it? Dr. Foster, I should like to call upon you to represent the Society and The Council in answering this question. The question is whether any member of The Council or the members of The Council feel that two meetings a year of the House of Delegates are desirable or necessary.

The Secretary: Mr. Speaker and members of the House, I think it is the consensus of many of The Council that there probably will be times when a second meeting of the House will be quite necessary, and I believe it is also obviously true that there may be many years when it will not be absolutely necessary. This amendment makes it mandatory that there be two meetings of the House.

If it is held in conjunction with the Postgraduate Institute in March it will mean, of course, that the whole period would be a five-day meeting, because it would be very undesirable to have the House meet at the same time the Institute meets, as that would interfere seriously with the attendance at the Postgraduate sessions.

I think the most important part of this is that it is mandatory in its present form, and the question is what you are going to do in those years when there will be no urge for such a meeting. If it could be so arranged that it might be called twice a year as business warrants, it seems that might be more practical. I believe that is the expression I have heard from the Councilors, all of whom have not been polled, however.

R. S. Breakey, M.D.: As you realize, this resolution was referred first by the Speaker of the House to the Reference Committee on Resolutions. That Committee considered the matter carefully, and felt that this particular part of the resolution did not fall within the province or under the jurisdiction of the Committee. Nevertheless, we recommended its approval as far as our expression of opinion was concerned.

It is true that the American Medical Association has been calling semi-annual meetings of its House of Delegates, and Dr. Foster has pointed out that it has been done by special call annually. There is an increasing amount of business to come before this House, as was cited in the original resolution.

About two years ago in Detroit the House did not disband until quarter after three in the morning, because of the urgent necessity and the amount of business we had to complete. Up to about two years ago there were three sessions of the House. For the last two years there have been four sessions. The constantly increasing amount of business to be considered by this House appears to your Committee on Resolutions, who had no power to act, to warrant such a semi-annual meeting in the interest of the Michigan State Medical Society.

If this has not been seconded, I should like to second it as a member of the House, who has found that the increasing business over a period of twelve months makes it difficult to accomplish our task with expediency.

T. K. Gruber, M.D.: Last night Dr. Johnson and I had a little session. He asked for a show of hands of those who wanted an extra session.

The Speaker: That was a show of hands—

T. K. Gruber, M.D.: —to give us an idea of whether they did or not.

The Speaker: Of whether they wanted to vote on it today?

T. K. Gruber, M.D.: No; whether they wanted the extra session or not; isn't that right?

The Speaker: That is right.

T. K. Gruber, M.D.: The show of hands certainly wasn't much in favor of it; otherwise I would have objected to putting in an amendment.

I am going to talk on the amendment. On page 134, Section 7, second paragraph, it reads: "A delegate, or in his absence the alternate delegate, becomes a member of the House of Delegates when properly registered and seated to the annual session following his election by the county society. His membership in the House continues until the next annual session."

So, you wouldn't need to revise the other part of the Constitution or By-Laws. Once he is seated in an annual session he remains a member until the next annual session. That was put in to obviate the special session. I remember when this article was put in; as a matter of fact, I think I wrote it, because we had a big argument about whether a man who was seated at the last session could attend the special session, or whether it would have to be someone else.

The Speaker: Your point is that once a delegate is seated at this session, he is a member of the House until the next annual session?

T. K. Gruber, M.D.: His membership in the House continues until the next annual session.

The Speaker: Dr. Gruber, what does that have to do with the

calling of a session semi-annually? Dr. Johnson, would you like to answer that?

R. A. Johnson, M.D.: As it is now worded in the Handbook, there is specified one meeting only, called the annual meeting. There will have to be an annual meeting, because at that meeting the officers and others are elected. This semi-annual meeting is mandatory if this present amendment under discussion goes through—if the amendment fails there is always the provision for a special session being called. The only reason for the amendment is to make a semi-annual meeting mandatory.

There is confusion, and probably a more extensive revision of the By-Laws than the one I have just read should be considered, because throughout the Handbook it appears that only one session of the House is called. It is my own feeling that if we revise this one paragraph, and if the amendment holds, no further revision is needed except in language. The intent of the House will take care of that aspect of it.

The Speaker: Is there further discussion on the proposed amendment?

W. S. Jones, M.D.: (Menominee): Does that amendment read "bi-annually" or "semi-annually?"

The Speaker: Semi-annually.

R. L. Wade, M.D.: This would provide for a meeting in March?

The Speaker: Yes.

R. L. Wade, M.D.: We have many colleagues in the Upper Peninsula, and March would be a very bad month for them to come here. I think it should be left to the Council to decide, instead of setting it in some month when bad weather is so prevalent in a lot of Michigan territory.

The Speaker: In other words, Dr. Wade, you would oppose the amendment and would leave it to the discretion of The Council to call a session as necessary?

R. L. Wade, M.D.: Yes.

S. L. Loupee, M.D.: What I have to say won't amount to much, but I am opposed to this amendment, and if I don't say this now no one will ever know I am opposed.

In the first place, I don't see any great need for it. I think in the days just passed we have shown we can contract considerable business expeditiously and accomplish what we have before us. We have done it before, and it can be done again.

First and foremost, to call us here in March makes a considerable demand upon the time of busy men at that time of the year. That is a personal matter. In the executive offices I am sure it will not be any easier for them to transact the business of the Society by having an extra session on their hands, because I know now that they no more than get one session out of the way than they begin to plan for another.

If we have a semi-annual session they will have to have extra help, there will be extra expense, and I can tell from Dr. Foster's discussion of this that he thinks it would be much better to leave it in the hands of The Council.

I prefer that it be left in the hands of The Council.

The Speaker: Any further discussion on the proposed amendment?

L. W. Gerstner, M.D.: Again, a personal matter but one we must consider: Many men can take their vacation in the early part of the year and can go to such places as Florida. They will have to make even greater sacrifice and vary their practice and rearrange even their vacation. I think the time of the meeting should be considered very carefully. I believe we should all think twice before we vote on this. Again, I am opposed to the amendment.

R. S. Breakey, M.D.: I wonder if the Chair would call upon Dr. Haughey from The Council to express his opinion?

The Speaker: Dr. Haughey is being called for an expression of opinion on the matter of the necessity of a semi-annual session of the House of Delegates.

Wilfrid Haughey, M.D. (Battle Creek): There is a long time between meetings, and with the social problems facing us now we should be able to get together and express ourselves a little more often. Maybe sometimes we won't need an extra session. If it is put in the By-Laws, it can be changed at any meeting, even at an extra-session meeting. So, it won't do any harm to call for some meetings we won't need. I do believe we should keep our fingers on the pulse of things a little more carefully than we have in the past.

L. E. Holly, M.D. (Muskegon): On page 115: "Special sessions of the House of Delegates shall be called by the Speaker on petition signed by two-thirds of the delegates seated at the last annual session of the House."

In order to give The Council the power to call a special meeting of the House of Delegates, which would take care of the whole situation, a short phrase could be added, "or upon call of The Council."

The Speaker: Dr. Holly, that is merely a suggestion, that the words "or upon the call of The Council" be added. However, I don't believe that can be considered in the consideration of this present amendment. That is not the same section we are amending, is it?

L. E. Holly, M.D.: No, but that could very easily be a substitute amendment.

The Speaker: It could not be a substitute amendment to this amendment, but after this is adopted or disposed of, one way or the other, you could propose that.

L. E. Holly, M.D.: In other words, there is no provision except on two-thirds vote of the delegates seated at the last annual meeting, to call a special session. If this amendment should be voted down, then the phrase "or upon petition of the Council" could be added to this Section 2 of Article IV, which would give the power to the Council to call an additional meeting of the House of Delegates.

The Speaker: Dr. Holly, if this amendment is voted down the Chair will be glad to give you the floor for the purpose of that discussion.

G. C. Penberthy, M.D. (Wayne): Mr. Speaker and members of the House, you will recall that The Council wisely decided to have a scientific meeting separate from a meeting of the House of Delegates at the annual session. Our first meeting last year was a great success, due to the interest taken by all who contributed to the program. If you call a meeting of the House of Delegates at that time, as has been expressed by some of the discussants, I am sure it will interfere to some extent with the scientific session.

True, I think it brings into the scientific aspect of the State Society's program something that is important; but there is something in the By-Laws which provides for a special session if necessary. We have an Executive Committee of The Council that meets and deliberates upon all problems, and carries them to the House of Delegates, and is in conference with them from time to time.

I support Dr. Gerstner's and Dr. Loupee's idea, and I think if it is necessary (with all this business, as has been mentioned) then a special session could be called.

A. H. Kretchmar, M.D.: Mr. Speaker, it is very difficult for me to see how a meeting of this House, before a scientific session, would interfere with the scientific session itself, because the business always comes first. I should think it would be a definite advantage to the Postgraduate Institute to have this House meet, because I believe it would aid in the increase in attendance at the Postgraduate Institute.

Men have expressed themselves on both sides about the rapidly changing order and the fact that when the House meets so much material is brought in that very often insufficient time is given to it. I believe that renders it imperative that we do have a second meeting of this House of Delegates.

The Speaker: Any further discussion on the proposed amendment? If not, the amendment on which we are voting is on Chapter 3, Section 1, and will provide for a compulsory regular semi-annual meeting at the time of the scientific session in March. Are you ready for the question? We will take a hand vote.

(The motion was put to a vote and was lost by a vote of 51 to 21)

The Speaker: The proposed amendment has been lost, as it requires only a majority vote anyway.

E. D. Spaloing, M.D.: I wish the privilege of the floor after this motion has been settled.

The Speaker: We will have the supplemental report from the Reference Committee on Resolutions. There will be time for new business if it is the unanimous wish of the House.

XIII. On Erroneous Newspaper Report

E. D. Spaloing, M.D.: Mr. Speaker, may I have the privilege of the floor concerning this morning's press release?

The Speaker: You may, if there is no objection.

E. D. Spaloing, M.D.: The officers of your Society are much concerned with the press. It was noted in the press this morning that "A rising vote of thanks in the House of Delegates yesterday afternoon was given Dr. DeKleine." To keep the record straight, may it be entered in the minutes now that no such action occurred.

I move you, Mr. Speaker, that a telegram to this effect be sent to the Governor, that the "Michigan State Medical Society is solidly behind you in your appointment of Dr. Altland as new Health Commissioner. Furthermore, you are privileged to use this wire in any way you see fit."

The Speaker: You have heard the motion concerning a telegram to the Governor.

E. C. Texter, M.D.: I support it, Mr. Speaker.

H. W. Wiley, M.D.: I disapprove of saying "solidly" because I am not in favor of this motion.

The Speaker: Dr. Spalding, according to the Constitution it is impossible to introduce new business unless it is with the unanimous consent of the members of the House. This motion has been objected to; therefore, it is not the unanimous opinion of the House, and the Chair is unable to recognize the motion unless you can figure some other wording.

E. D. Spaloing, M.D.: Mr. Speaker, a motion should go into the minutes. Is it not the unanimous feeling of this House that some action should be taken on this matter, to set things straight?

The Speaker: Dr. Spalding, if you care to move that we lay aside the rules, certainly this would be within the province of the Constitution. However, a motion is new business.

E. A. Osius, M.D. (Wayne): For general information, there was a rising vote of thanks yesterday afternoon at the Michigan Medical Service meeting for Dr. Novy.

C. I. Owen, M.D.: What's the matter with the Press Committee?

The Speaker: The Press Committee has met with the press after every session. Certainly this member of the Press Committee is unable to account for this article in the *Detroit Free-Press*. The Chair awaits the pleasure of the House in this matter.

T. K. Gruber, M.D.: Mr. Speaker, I object to another statement in that same article, that the Wayne delegation opposed the $25 assessment.

The Speaker: What is the pleasure of the House in this matter?

H. H. Riecker, M.D.: I move suspension of the rules to permit Dr. Spalding to present his motion.

E. G. Krieg, M.D.: I support the motion.

The Speaker: It is moved and supported that we suspend the rules to permit Dr. Spalding to put his motion. Any discussion?

(The motion was put to a vote and was carried, but not unanimously)

The Speaker: The motion is passed. Dr. Spalding, will you please restate your motion?

E. D. Spalding, M.D.: A member arose and stated he has his own views to the contrary. That is perfectly within his rights, and therefore this motion should not be quite as I had put it. May I change it to this effect:

I move that a wire be sent to the Governor, to the effect that "The Michigan State Medical Society is behind you in your appointment of Dr. Altland as new Health Commissioner, and furthermore you are privileged to use this wire in any way you see fit."

I so move, sir.

E. C. Texter, M.D.: Second the motion.

W. B. Harm, M.D.: Mr. Speaker, it sounds to me like a lot of poppycock. It is already in the paper, and I think our Governor is smart enough not to believe everything he sees in the paper. If he does believe everything he sees, he is going to have an awfully tough time in the coming year.

Haven't we a public relations director or press man hired by this Society, who is supposed to take care of these things?

The Speaker: Dr. Harm, I should like to ask Dr. Ledwidge to answer both of your questions.

P. L. Ledwidge, M.D.: Mr. Speaker, in answer to Dr. Harm and for information to the others, we feel that this motion is distinctly in order and should be supported, for these reasons:

In the first place, it is an absolute misstatement of fact. There was no such notice authorized by our Press Committee. We don't wish to be misquoted. Moreover, this topic under discussion is not being brought up for the first time. It has been in the press for some time past, and has created a lot of trouble for the Governor of our State. A statement of that kind definitely puts us in bad with the Governor. That is a condition we cannot afford to have exist.

The motion should be passed, and whether it is passed by unanimous vote or by three-fourths vote, or whatever is necessary, according to our Speaker, it should be entered as the Michigan State Medical Society being solidly behind it, because the Michigan State Medical Society is solidly behind every action of the House of Delegates.

The Speaker: Thank you. Is there any other discussion?

C. I. Owen, M.D.: It might be advisable also to add to that telegram the statement that this House did not give a rising vote of thanks, as was stated in the press. Maybe the Governor would like to know that, too.

The Speaker: Do you care to add that as an amendment?

C. I. Owen, M.D.: I will.

The Speaker: The amendment has been proposed that it be included in the telegram this House would send to the Governor, that this House did not give a rising vote of thanks to Dr. DeKleine as stated in the *Detroit Free-Press*.

J. A. Kasper, M.D. (Wayne): Second the motion.

E. D. Spalding, M.D.: That was all stated in just so many words by me at this microphone. Do you want to repeat my words?

The Speaker: Dr. Owen, do you care to have the motion repeated?

C. I. Owen, M.D.: Yes.

E. D. Spalding, M.D.: I don't want to bore you with this, gentlemen, but it is a matter of some political importance to this organization that this matter be correct.

I made the statement that it has been noticed this morning in the press, quoting the press itself, "That a rising vote of thanks at a meeting yesterday afternoon in the Michigan State Medical Society was given Dr. DeKleine," and I made the statement, to keep the record straight, "May it be entered in the minutes that no such action occurred." That is specific.

C. I. Owen, M.D.: No; I want it in the telegram to the Governor.

E. D. Spalding, M.D.: A lot of things can be gotten to the Governor that don't have to be made quite this way.

Then I moved that a wire be sent to the Governor to this effect: "The Michigan State Medical Society is behind you in your appointment of Dr. Altland as new Health Commissioner, and furthermore you are privileged to use this wire in any way you see fit."

If you wish to change it, you may. That is the way I stated it.

C. I. Owen, M.D.: My amendment stands.

The Speaker: We are now discussing the amendment to include the phrase, "and a rising vote of thanks was not given," and so on. Any further discussion on the amendment?

P. L. Ledwidge, M.D.: Mr. Speaker, does the amendment say "in the press"?

The Speaker: ". . . in the press."

R. H. Denham, M.D.: This is an Associated Press dispatch. Why not lay the blame at the door of the Associated Press?

(The amendment was put to a vote and was carried unanimously)

(The motion as amended was put to a vote and was carried unanimously)

The Speaker: The next order of business is the supplemental report of the Reference Committee on Resolutions. Is Dr. Breakey here? Incidentally, the Chair will ask that Secretary Foster send the telegram at once, as indicated by the House.

R. S. Breakey, M.D.: There are two resolutions to be considered. It may not be of interest to the House, but these two resolutions took up more time in the Committee than all the others that have been presented.

XII—f. DEFINITION OF MEDICAL SERVICES IN MHS CONTRACT

The first resolution is submitted by Dr. Armstrong:

"WHEREAS, the services of the pathologist, roentgenologist, anesthesiologist and physical therapist are medical services, and

"WHEREAS, Michigan Hospital Service wrongfully offers two of these services (pathology and anesthesiology) to the public as benefits under hospitalization insurance policies, and

"WHEREAS, Michigan Hospital Service, the Blue Cross plan covering the State of Michigan, has failed to discontinue this practice and has in fact encouraged the practice of one of these specialties (anesthesiology) by laymen, and

"WHEREAS, the House of Delegates of the American Medical Association has gone on record as strongly disapproving this practice of encroachment; therefore, be it

"RESOLVED: That the Medical Society of the State of Michigan, through its House of Delegates, reaffirms its disapproval of this practice; and be it further

"RESOLVED: That this House of Delegates instruct our representatives on the Board of Trustees of the Michigan Hospital Service to oppose this encroachment on the private practice of medicine; and be it further

"RESOLVED: That the Secretary of the Michigan State Medical Society be instructed to notify each county medical society of this action, and advise the medical boards and individual members thereof of the importance of establishing in their hospitals the principle that the practice of pathology, roentgenology, anesthesiology and physical therapy is the practice of medicine and not a hospital service; and that the hospital board of directors be asked to discontinue the inclusion of these medical services in any contract for hospital services."

Your Committee had this matter under advisement for two and a half hours. The resolution was disapproved unanimously because of the multiple implications and without definition exactly of what constituted pathology as rendered. The pathologists submitted a proposed amendment stating that the words "anatomical and clinical" be used, which would include a blood count or a urinalysis. There was no limitation in accord with this resolution. There was an apparent lack of clarity. There was no disagreement on the part of your Committee as to the principle involved, and the Committee recommended to the sponsors of the resolution that a new resolution be formulated and submitted to subsequent meetings of this House.

The action of the Committee is to disapprove this amendment. I so move, Mr. Speaker.

H. H. Riecker, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously)

XII—f. ON BASIC SCIENCE LAW

R. S. Breakey, M.D.:

"WHEREAS, the basic science law or Public Act 69, designed to regulate the practice of healing in the State of Michigan and to provide for examination in basic sciences as a prerequisite to eligibility to practice the art of healing in this state, has now had a trial period of several years, and

"WHEREAS, the theory upon which this law was enacted was that it would raise the standards of medical practice in this state, and

"WHEREAS, this law has proved to be an insurmountable barrier to all medical graduates from outside the State of Michigan, and

"WHEREAS, experience has shown that the results obtained have not confirmed the theory upon which the law was enacted, and that the rigid examinations exclude from certification practically all candidates for licensure, with the exception of those examined immediately following the basic science years in medical school, and

"WHEREAS, the hospitals in Michigan which offer approved residency training in the various specialties have been and will continue to be avoided, because of this law, by medical graduates from other states who have excellent scholastic and internship records, and

"WHEREAS, the long waiting period necessitated by the examinations, the expense of travel and fees, the uncertainty of certification, and the weeks of review of all subjects obviously influence these men to accept an appointment in some other state, and

"WHEREAS, the educational opportunities for postgraduate training at the medical centers and in hospitals in this state are not available to all applicants for such

training because of the stringent requirements of this law, and

"WHEREAS, for the intent and purpose of protecting the health and welfare of the people of this state it is desirable that medical graduates who show promise of leadership be attracted instead of repelled from this state, and

"WHEREAS, medical licensure by reciprocity with other states is nullified by the existing basic science law, and

"WHEREAS, the basic science law is a detriment to the future of good medical practice in this state, impedes postgraduate training, and deprives the hospitals of the services of the best among applicants for resident training; therefore, be it

"RESOLVED: That the House of Delegates of the Michigan State Medical Society urge that this law be repealed and a substitute bill introduced to remove the objectionable features of the present law."

Your Committee would like to state, first, that at the beginning of its hearing there was some confusion as to the wording of the "Resolved," and we called Dr. Darling, who had submitted the resolution, to appear before the Committee and clarify the questions.

Several of the discussants, including myself, were uncertain as to whether this actually meant "repeal," which is in writing and is crossed out. Dr. Darling clarified the matter so that the "Resolved" paragraph reads like this:

"Resolved: That the House of Delegates of the Michigan State Medical Society urge that this law be amended to remove the objectionable features of the present law."

Gentlemen, your Committee moves the adoption of this resolution.

E. C. Texter, M.D.: Second the motion.

The Speaker: It is moved and seconded that the amendment concerning the recommendation that the basic science law be amended, be adopted. Is there any discussion?

R. H. Pino, M.D.: In view of the time that has been spent with the Board on the basic science law by the Commission on Health Care, I would like to discuss this.

I have not sat in on any of the meetings here that have had to do with the formulation of this resolution, and I feared this very much, for this has been talked about a great deal, namely, that the basic science law be repealed.

I am very happy to notice that this says it should be amended. If it can be amended to conform to the spirit of the men who brought in this resolution, that will be fine, and I don't see why it cannot be amended. I will vote for this resolution.

However, we must bear in mind that we will not be through with this subject until we have a common Medical Practice Act, and that may take a very long time.

It is my opinion, based on our studies, that this should pass.

H. L. Morris, M.D.: I would like to know what the proposed amendments are. Those who wrote this resolution evidently overlooked the fact that the students at Wayne and the University of Michigan are extremely carefully screened before they are admitted to the University.

Are we to assume that out of a clear sky, at the termination of their medical studies, that they are an inferior group and are not capable of carrying on in our hospitals as interns and residents in our own state? This question has come up repeatedly concerning the inadequacy and the unfairness of the basic science law, and perhaps it does have some flaws; but those who propose the amendment—I would like to know what the amendments are, and why it is necessary for those of us in the medical profession to feel we should have an amendment and allow boys from other states to come here and take positions as residents in our hospitals.

Primarily we have good teaching institutions in our own state. That question has come up time and time again regarding replacing some of our old graduates, primarily boys from Michigan who have been educated in our own schools.

I am not in favor of kicking this basic science law over at this time. It has served its purpose and will continue to do so until the thing is definitely taken care of in a different manner. To vote upon some vaguely stated amendments I do not think is good policy.

R. H. Pino, M.D.: I understand what Dr. Morris means. The President of the National Organization of Basic Science Boards tells us we have to depend upon what they bring to us, that we are working now to make it a common Act for every state. When that is done it will help a great deal. That will amend it, Dr. Morris. That will be an amendment. It is not working well now. One reason why it isn't working well is because the law isn't being lived up to. If the law were being lived up to, these boys would just as soon go ahead and review and get ready for these boards, and wouldn't think anything about it.

But the osteopaths get by this board all the time. If they matriculated in a school thirty years ago—a school of osteopathy—and then stopped for twenty-five years and did nothing more about it, and then went to a school of osteopathy and went through it, that exempts them from the basic science law. There is a point for amendment.

It either needs to be repealed or it needs to be fixed, because any law that isn't lived up to isn't a law. Any law that can't be lived up to is only as good as public opinion makes it. I am sure that the men who are working on this in a national way, to make it uniform, can make some changes that will fix it so we won't have to just take it out of the books. When we do that the osteopaths and chiropractors and all the rest will say, "They put that law on the books to hold us back," which is true, and that we couldn't make it stick because it didn't have public backing.

I still think this resolution should pass.

R. S. Breakey, M.D.: Mr. Speaker, may I speak as Chairman of the Committee of Reference. I am sorry I neglected to add that the recommendation of the Committee was to adopt the resolution to amend, and further, to refer this matter for consideration to the Legislative Committee of the Michigan State Medical Society. I should have stated that earlier.

As far as your Committee knows, the exact amendments or means of amending we have not been advised of; nevertheless, we have added in our recommendation that the matter of amendment be referred to the Legislative Committee. I add that, Dr. Morris; it should have been included first.

The Speaker: If it is agreeable with the delegate who seconded the motion, this will be included in the motion because it is the decision of the Reference Committee. Dr. Texter, didn't you support this? Is it agreeable with you "that this be referred to the Legislative Committee of the Michigan State Medical Society for consideration" be added?

E. C. Texter, M.D.: That is agreeable.

S. L. Loupee, M.D.: At the last session of the legislature a bill was introduced amending this basic science law. The bill was sponsored by the chiropractors. They wanted to get out from under some of the provisions of the Basic Science Act. We defeated it, as you all know: If they were here today they would think they had some help, perhaps, in their efforts to amend the Act.

We must be very careful, in our modification of this Act, that we do not open the gate and permit a thousand proposals to creep in which will weaken the intent and purpose of this Act.

I am not so sure but that the spirit of the Basic Science Act is circumvented by the Basic Science Board in the rules which they publish. Within recent years the legislature has provided that the rules of all these boards are subject to legislative review. Within the last few months there has been established, as you all know, a Legislative Committee which has the right to review the actions of all these boards.

It appears to me that it would be a good thing, before we undertake to amend this Act, to bring the action of this Board into review by the Legislative Committee. It is just barely possible we might soften the rulings of the Basic Science Board to the extent that they would enforce the spirit of the law as well as the letter of the law.

T. K. Gruber, M.D.: I think the basic science law is all right as it is. The difficulty is with the application of the Medical Practice Act by the State Board of Medical Registration. I think everyone understands that.

The Michigan State Board of Medical Registration set up certain rules and regulations, and I hope that Board is investigated by the Board Dr. Loupee spoke of. Their contention is that if a man has a one-year internship, that is all the internship he can have. If he makes certain applications he can have a second year of internship. On June 30 (if he starts the first of July) he is writing orders in hospital order books, and on July 1 he isn't capable unless he has a license.

It is my contention that the Michigan State Board of Medical Registration could allow men to have their periods of training, internship, assistant residency and residency, without a license to practice. They are still practicing under the direction of the staff, and if that were done you wouldn't have this argument about the basic science law at all.

If you are going to start to amend this, I can tell you the tenor of the legislature, and Dr. Loupee can, too. Start monkeying with it and you will get something you'll wish you had never heard of, or you will have it thrown out entirely. There were several legislators who spoke to me when I appeared in Lansing on various occasions, who said the law ought to be thrown out. They are anxious to throw it out.

I still feel this law is all right if the application of the law is made by the Michigan State Board of Medical Registration. I think this Society could very well have a meeting with the committee Dr. Loupee spoke of, in the Senate or the House, whichever it is, and try to have their rules and regulations changed.

R. H. Pino, M.D.: Mr. Speaker, will we have this law thrown out entirely, or will we have it amended? There is a National Board of Examiners having to do with licensure of doctors. Many doctors take that. I am not sure how many states, but there are many states that recognize the National Board. What do they do? At the end of the first two of the last four years of the medical student, they give an examination on the basic sciences in medicine, and then at the end of the fourth year, before that man goes into an internship, they give him the other. I don't know how popular that National Board is, but I know their technique. It is this: They believe the student is much better able to write his examinations in anatomy and in those basic sciences when he has finished them. If he has been passed in a good medical school—his professors know whether he should be passed or not.

There has to be an amendment (if we are going to make this matter work well) and it should be on a national basis so that the basic science examination can be given at least at the time the student graduates. If you wait until the student has been out for three or four years—see what happened to these men who went to war and then came back! Now they have to go back and review it all over again. That is very hard to do.

The people who give the examinations are not doctors of medicine, who could be very lenient. They are professors of chemistry and other subjects of that sort. It is very difficult for many of these fellows to get through. So the osteopaths are getting through based on the fact that they matriculated twenty years ago, and these boys don't like it at all.

Dr. Loupee, I would think that a simple amendment could be

made without throwing the whole thing overboard. If it is going to throw it all overboard, then let's not have any amendments nor any monkeying with it. Isn't there a way to think this through?

E. A. Osius, M.D.: I want to endorse Dr. Gruber's stand on this matter. I think we are going round-about, and a very dangerous way, to do something that can be achieved in a much simpler fashion.

I have a lot to do with the interns of the hospital in which I happen to be, and the point always comes up in this basic science law, and it is a difficulty in keeping good men. I believe that having an exchange between the states, as far as hospitals are concerned—in other words, not exclude men from out of the state in hospitals here—would be good for all concerned. I am heartily in favor of such an exchange of ideas.

Basically this resolution has to do only with residents, when you boil it down. Can a resident stay in my service without taking the basic science law? That is all the resolution asks for. That can be achieved through the Board of Medical Registration. There has been some difficulty getting co-operation from that Board. I would like Dr. Ledwidge, if he wishes, to say a word or two about that, because it has been discussed elsewhere.

The Speaker: Dr. Ledwidge, the request has been made that you say a word or two about the work you are doing with the Board of Medical Registration in Medicine, or at least your attitude concerning it We are discussing the basic science law.

P. L. Leowidge, M.D.: You were all here the other day when I made my remarks. I spoke about it then. There has been a lot of difficulty in hospitals that have second-year teachers and third- and fourth-year residents. This difficulty was noted by the House of Delegates in 1945. The difficulty was this:

The ruling at that time was that a boy who had graduated from medical school was compelled to have one year of rotating internship before he could be licensed to practice medicine. That is a requirement of the Board of Registration. Also, the ruling of the administrative Board was that before an intern could take up his second-year internship he must be licensed to practice medicine.

That created a hardship upon the interns and on the hospitals, who wanted second-year interns and third- and fourth-year residents, because many of these fellows came from out of the state. They had to take the basic science law of this state. The times were not properly set, and they did not have time to get through their basic science examination and their Board of Registration in Medicine examination; so there was that hardship.

The House of Delegates in 1945 requested that the Board of Registration undertake or institute remedial measures for this. Following that action by the House of Delegates in 1945 the Council of the Michigan State Medical Society had our legal adviser, Mr. Herbert, study the statutes and the administrative rules. After careful study he decided that the administrative rules of the Board of Registration in Medicine could be so changed as to permit second-year interns and third- and fourth-year residents to continue their education in approved hospitals, and under proper supervision. without being licensed to practice medicine.

Following this, in January, 1946, the Council petitioned the Board of Registration in Medicine to make that change in the administrative rules. The changes necessary were outlined by our legal adviser. The Board of Registration in Medicine was very cautious about that, perhaps rightly so. They were quite reluctant at that time, for reasons that were not clearly stated, to license third- and fourth-year residents. However, they did permit second-year interns to go through their second-year internship before they were compelled to be licensed to practice medicine.

As I said the other day, it was a big help and was much appreciated by all concerned.

On the other hand, there is still much difficulty about the third- and fourth-year interns. There are many who want to come here for training but not necessarily want to stay in the State of Michigan to practice. It is part of their education, and not the practice of medicine. We have felt that if that ruling could now be made it would do away with a lot of this criticism of the basic science law. We don't feel that it answers everything, but we think it would be a big help and it could be made by a simple ruling of the Board and could be given immediate effect. which would mean that when a fellow has graduated from medical school he would be privileged to take four full years of training, under proper supervision and in approved hospitals—and I mean by that approved for resident training—without being licensed to practice medicine.

Does that make it clear?

E. A. Osius, M.D.: Thank you very much, Dr. Ledwidge. If you remember back a few years, we made a very strong and arduous plea to have this basic science law put in. We put it in for a very definite reason. It has been a big bulwark against a good many encroachments as far as medicine is concerned. and the decent practice of medicine, in this state. If we begin to pick away at it a little bit, as Dr. Gruber said, there will be a deluge in a short period of time.

I think the important thing to do is to reject this resolution and to take some other steps to achieve what actually this resolution wants. Boiled down to a few words, all it asks is that "I would like to keep a good man on my service for four years without having him take the basic science law." That is all the resolution says.

P. L. Leowidge, M.D.: May I make one other statement of explanation? The Council, in its annual report, as you perhaps recall, stated that they were going to make this request of the Board of Registration in Medicine to allow these third- and fourth-year interns this privilege. The Council is going to ask that of the Board of Registration in Medicine, and in my statement I recommend approval of this be given by the House. We wanted your endorsement. You did endorse that by approving the President-elect's address. So you have already approved that part of the action.

R. H. Pino, M.D.: Mr. Speaker, I would like to ask this question so that I might carry home an opinion: Is it the opinion of Dr. Loupee, and others who are thinking about this, that we should say to the National Organization of Basic Science Boards that we do not believe Michigan wants to have its basic science law changed to conform to a national basic science law, and so we can't support them?

They came in hopefully wanting to get information to help them. They see how difficult it is and how it isn't working well. I want to go along with the discussion, because it is enlightening. Shall we say to them, "No, we don't want to change it even to have it become more uniform"? If it is impractical to try to do that, I will believe what you say, and we will tell them so.

S. L. Loupee, M.D.: That is a very good question. The answer is just this: When the National Board has a program and they have something definite to offer Michigan, when they have something that other states have already adopted, then we need not fear to bring it to the Michigan Legislature, and I think you will get some action. After all, the legislature is very friendly to concerted action on the part of states in such matters as this.

When you begin to pick at this particular law without having some national program to offer them, then you must watch out, because the outlook of the ordinary legislator is altogether different than it is if he hopes to co-operate with the nation at large. Then I think you can tell your National Board, "Sure; we have a program and it's all right to send it to Michigan. We'll put it over."

R. H. Pino, M.D.: That is all we want to do.

R. V. Walker, M.D.: Mr. Speaker, I have been interested in this basic science law because I happen to be a member of one of the committees who worked so hard for it back in the late '30's. That was a stepping-stone, supposedly, and I still think it is a barrier against the coming in of improperly trained healers of other cults. I don't think anyone believes there is anything wrong with the basic science law itself. Perhaps some of you don't realize that about two years ago some of the out-of-state respected residents would go up to Minnesota and take that basic science board because it was found to be easier to pass than the Michigan Board. That type of Michigan Basic Science Board had reciprocity with Minnesota, and they found that loophole. Since then they have discontinued reciprocity through that means.

As I see it, the law we have (which should be a barrier against improperly trained men from the cults) stems back to the State Board of Registration in Medicine. If they can interpret it in a manner suitable for the need of hospitals, the problem will be solved right there. It isn't a matter of changing the law.

As Dr. Loupee has said so well, as soon as you try to make amendments the osteopaths and chiropractors will have just as much right and will use just as much logic from the point of view of the legislators to change it to suit themselves. Why not have something that is good at the present time?

H. L. Morris, M.D.: In the first place, there are only thirteen states that have basic science laws. Secondly, through various wordings of technicality, whether "hygiene" or "public health" or some other phraseology which the examinee is examined in, the thirteen states do not have a uniform basic science law as applicable to all.

The Basic Science Board is working on that problem, and it has to be changed by legislative action to make a uniform set of subjects in which to be examined. This is not the opportune time to fuss with the basic science law as we have it here.

Next, the National Board of Examination, with which we are all familiar, and which is an excellent Board and gives probably the best medical examination to anyone for licensure, is a lay board. They have no standing legally in any state in the Union. The boards of licensure recognize that the boys who pass the National Board are really examined, both written and orally, and are competent individuals.

In the third place, I happen to be a member ex officio, extracurricular, so to speak, of the Board of Registration, and there will be a meeting this afternoon of that Board. I don't think there is any question but that these difficulties which you gentlemen have presented, relative to your second-, third- and fourth-year men, will be satisfactorily ironed out and taken care of to your entire satisfaction. It is within the power of the Board and their own rules, which they make, to keep these fellows on as long as you want them.

If it is to be an approved hospital only, that certainly would help the Board in deciding how to handle the situation.

R. S. Breakey, M.D.: Mr. Speaker, I should like to ask Dr. Morris whether or not arrangements have been made for authorized representatives of the State Society to appear before the Board this afternoon?

H. L. Morris, M.D.: Not that I know of. I will be there.

R. S. Breakey, M.D.: Following the disposition of this motion. I should like the floor.

H. H. Riecker, M.D.: Is a motion for a five-minute recess in order?

The Speaker: It is possible for you to make a motion to recess for five minutes.

H. H. Riecker, M.D.: I move to recess for five minutes.

C. K. Hasley, M.D.: Second the motion.

(The motion was put to a vote and was lost)

The Speaker: The question on the floor is the motion to adopt the resolution. I guess you know what the resolution is. Is there further discussion? The resolution will be read again.

R. S. Breakey, M.D.: "Resolved: That the House of Delegates of the Michigan State Medical Society urge that this law be amended to remove the objectionable features of the present law, and referred to the Legislative Committee for action."

L. G. Christian, M.D.: I would like to offer an amendment, that it be referred to the Legislative Committee of the Michigan State Medical Society, and any changes offered at the discretion of The Council." I don't like to have this made mandatory, as Dr. Loupee has pointed out. It may be dangerous to open it up.

THE SPEAKER: Will you state that gain? You propose that this be referred to the Legislative Committee of the Michigan State Medical Society—

L. G. CHRISTIAN, M.D.: —and any changes to be proposed be reviewed by The Council of the Michigan State Medical Society.

THE SPEAKER: That is the amendment proposed. Is there any support?

E. A. OAKES, M.D.: Second the motion.

THE SPEAKER: The question before the House is the vote on the amendment proposed by Dr. Christian. Is there any further discussion on the amendment?

(The amendment was put to a vote)

THE SPEAKER: The Chair is in doubt. We will take a hand vote.

(There were 59 "Yes" votes)

THE SPEAKER: We don't even have to count the hands. The amendment is passed.

H. H. RIECKER, M.D.: Mr. Speaker, I would like to state my position. We would like to have the Washtenaw delegation have a little time to confer about it. Couldn't you grant us a few minutes? May we not recess to do this? I don't think it is unfair to ask.

THE SPEAKER: The floor is open for Dr. Riecker to make a second request, if he cares to. The Chair cannot grant a recess, or does not feel he should, unless ordered by the House.

L. J. BAILEY, M.D.: We have had a lot of discussion about this, and it would seem to be the consensus of opinion that there is some merit in the resolution, but that the time is not ripe.

Therefore, I move to table this until the next meeting of the House of Delegates.

W. D. BARRETT, M.D. (Wayne): Second the motion.

THE SPEAKER: It is moved and supported that the motion be tabled.

E. D. SPALDING, M.D.: You can't.

THE SPEAKER: It is moved and supported that the motion be tabled until the meeting of the House of Delegates next year.

(A hand vote was taken and the motion to table was passed by a vote of 48 to 28)

THE SPEAKER: The motion is tabled. Is there any further business to come before the House, Dr. Breakey?

R. S. BREAKEY, M.D.: Mr. Speaker, I move that the report of the Reference Committee on Resolutions be adopted as a whole, as amended.

E. A. OAKES, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously)

THE SPEAKER: Dr. Mitchell will report for the Reference Committee on Reports of The Council.

XII—b. ON REPORT OF THE COUNCIL—STUDY OF MEDICAL PRACTICE ACT

W. B. MITCHELL, M.D.: Mr. Speaker, this is a supplemental report regarding a study of the Medical Practice Act. This is a committee of The Council of a fact-finding character. Its work is not completed, but when it has a definite recommendation to make it will be given to the membership through the proper channels.

The Committee is exploring the possibilities of changing the Medical Practice Act with a view to solving the general problems of all the healing arts.

Mr. Speaker, I move that this be received and filed.

W. W. BABCOCK, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously)

W. B. MITCHELL, M.D.: I move you, Mr. Speaker, that the report of the Reference Committee on Reports of The Council be accepted as a whole.

T. Y. HO, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously)

THE SPEAKER: Is there any new business to come before the House?

T. K. GRUBER, M.D.: Mr. Speaker, I ask for the privilege of the floor to present a document to implement the revision of the Constitution and By-Laws. I presented a revision of the Constitution. It must be without a dissenting vote.

THE SPEAKER: If you propose new business, new business can be taken up only without a dissenting vote. Is there any objection to Dr. Gruber presenting this matter to the House? If not, you have the floor.

IX—c. PROPOSED AMENDMENTS TO BY-LAWS

T. K. GRUBER, M.D.: Mr. Speaker, the committee appointed by The Council to consider and report on revision of the Constitution and By-Laws presented the beginning of the revision in presenting a revision of the Constitution on Sunday night. I purposely did not bring the rewritten By-Laws in until the last session so they could not be acted on at this session. It must be carried over until next year. A revision of the Constitution and By-Laws has to be done at once or else there will be a hodgepodge.

I propose the following amendments to the By-Laws of the Michigan State Medical Society:

Strike out Chapters 1 to 9 inclusive, and substitute the following, Chapters 1 to 13 inclusive. I will ask permission to read them by title.

THE SPEAKER: If no objection is expressed, Dr. Gruber may read the proposed amendments by title. They will be published in THE JOURNAL before any action. [To be published in January, 1948, issue as approved.]

T. K. GRUBER, M.D.: I propose, further, to amend by renumbering Chapter 10, which is the matter of amendments, to Chapter 14.

Mr. Speaker, I move that these be referred to the special committee which was appointed on Revision of the Constitution and By-Laws for streamlining, as was done with the revisions to the Constitution.

THE SPEAKER: You have heard the motion that the amendments to the By-Laws, as contained in these papers, be referred to the Committee on Revision of Constitution and By-Laws.

E. D. SPALDING, M.D.: Support.

(The motion was put to a vote and was carried unanimously)

THE SPEAKER: Is there any other new business to come before the House?

D. C. BLOEMENDAAL, M.D.: Last night when I got home some of the doctors asked me what the fees were going to be for this year, and I didn't know.

THE SPEAKER: Dr. Foster, can you answer Dr. Bloemendaal? What will be the fees for membership this year?

THE SECRETARY: They will be identical for other years, $12 dues and $25 assessment, $37 to the state regardless of what you charge locally.

THE SPEAKER: Is there any other new business to come before the House? If not, we will proceed to the matter of elections. Turn to page 11 and you will find they will be taken up in order.

R. S. BREAKEY, M.D.: Mr. Speaker, I asked if I might have the floor following disposition of the last motion.

THE SPEAKER: That's right, you did. The Chair granted you the privilege. If there is no objection, we will dispense with the regular order of business and give Dr. Breakey the floor. Is there any objection?

R. S. BREAKEY, M.D.: I previously requested it.

THE SPEAKER: That is right.

R. S. BREAKEY, M.D.: In revision of the basic science law, on which I have only reported the recommendations of the Committee as Chairman of your Committee of Reference, and expressed no personal opinion, I should now like to express such an opinion. This is not opening any new business, gentlemen.

Dr. Morris stated that there would be a meeting of the Board of Registration this afternoon. Dr. Gruber stated that the interpretation of the rules of the Board of Medical Licensure could be adjusted to facilitate the range of problems confronting various hospitals and the applicants for internship and postgraduate training. Those statements have been made.

We hear that the Board meets this afternoon, and I have just been advised that there is no authorized representation from the Michigan State Medical Society nor from this House to appear before that Board.

I should like to move that the President of the Society be authorized to appoint representatives from the House of Delegates or from The Council to appear before the Board of Medical Registration and Licensure this afternoon, to present the problem as it confronts us.

T. K. GRUBER, M.D.: Second the motion.

P. L. LEOWIDGE, M.D.: Mr. Chairman, I would like to have the floor for a moment.

The Board of Registration in Medicine has all that information in writing. Dr. MacIntyre has his file, and he can present it as well as we can.

R. S. BREAKEY, M.D.: I am advised by Dr. Morris that the meeting is this afternoon. The House was so advised.

P. L. LEOWIDGE, M.D.: You are asking that a committee be appointed?

R. S. BREAKEY, M.D.: I am asking that personal representation be there.

P. L. LEOWIDGE, M.D.: Well, there are reasons why we would rather not do it that way. May I say that?

R. S. BREAKEY, M.D.: Certainly.

P. L. LEDWIDGE, M.D.: There are reasons why we would rather not do it that way. This can be handled—it has been handled for a period of two years, and we really would like to handle it in our own way. If you want a committee there, perhaps something could be done about it, but it's not necessary.

R. S. BREAKEY, M.D.: Mr. Speaker, out of respect to the wisdom and experience of our President-elect, I wish to withdraw my motion.

THE SPEAKER: Do you accept that, Dr. Gruber?

T. K. GRUBER, M.D.: Yes, sir.

THE SPEAKER: The motion is withdrawn. We will proceed to the regular order of business, which is the election of officers.

XIV. Election of Officers

We will begin with the election of Councilor from the Seventh District. These nominations must be made by a delegate from the Seventh District.

XIV—a. COUNCILOR—SEVENTH DISTRICT

GEORGE WATERS, M.D.: It gives me very great pleasure to place in nomination the name of Dr. T. E. DeGurse to succeed himself.

THE SPEAKER: Are there any other nominations for Councilor of the Seventh District?

C. W. OAKES, M.D.: I move the nominations be closed and the Secretary cast the ballot.

E. A. OAKES, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously)

THE SPEAKER: Nominations are now open for Councilor of the Eighth District.

XIV—b. COUNCILOR—EIGHTH DISTRICT

M. G. BECKER, M.D. (Gratiot-Isabella-Clare): I place Dr. Barstow in nomination to succeed himself.

THE SPEAKER: Are there any other nominations for Councilor of the Eighth District?

L. C. HARVIE, M.D. (Saginaw): I move that the rules be suspended and that the Secretary cast the unanimous ballot for Dr. Barstow.

R. A. JOHNSON, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously)

XIV—c. COUNCILOR—NINTH DISTRICT

THE SPEAKER: Nominations are now open for the position of Councilor of the Ninth District. Dr. E. F. Sladek, M.D., Traverse City, is the incumbent.

C. E. LEMEN, M.D., (Grand-Traverse-Leelanau-Benzie): I should like to take this opportunity, on behalf of the delegates of the Ninth District, to thank Dr. Sladek for his many years of service to our District. Dr. Sladek has elected not to accept the nomination for Councilor this year.

Therefore, I would like to nominate Dr. Elery Oakes of Manistee. Dr. Oakes has been a member of this House for some fifteen years, and we of the Ninth District feel he can very adequately and fairly represent our District on the Council.

THE SPEAKER: Are there other nominations for the position of Councilor of the Ninth District? What is the pleasure of the House?

DR. RODGER (Antrim): I move that the rules be suspended and the Secretary be instructed to cast the unanimous ballot for Dr. Oakes.

J. J. O'MEARA, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously)

XIV—d. COUNCILOR—TENTH DISTRICT

THE SPEAKER: Nominations are now in order for the position of Councilor of the Tenth District to succeed Dr. F. H. Drummond.

W. S. STINSON, M.D. (Bay): Mr. Speaker, I would like to nominate Dr. Fred H. Drummond to succeed himself as Councilor of the Tenth District.

THE SPEAKER: Are there other nominations? What is the pleasure of the House?

W. E. NESBITT, M.D. (Alpena): I move that the rules be suspended and that the Secreary cast the unanimous ballot for Dr. Drummond.

C. S. CLARKE, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously)

XIV—e. DELEGATES TO AMA

THE SPEAKER: The next order of business is the election of delegates to the American Medical Association to succeed Dr. L. G. Christian of Lansing, Dr. F. E. Reeder of Flint, who are incumbents in the position. According to the Constitution it is necessary to nominate two or more names. If more than two are submitted, voting must be by closed ballot. Nominations are now in order.

A. D. ALLEN, M.D.: I nominate Dr. Christian to succeed himself.

G. C. PENBERTHY, M.D.: I second that motion.

A. H. KRETCHMAR, M.D.: I would like to nominate Dr. Ray Morrish, a Past-President of the Michigan State Medical Society, and one who has given many years of service.

THE SPEAKER: Are there other nominations?

W. B. MITCHELL, M.D.: Mr. Speaker, I would like to place in nomination the name of a man who has been working for the Michigan State Medical Society for many years, on many committees, a Past-Treasurer of the State Society, and now just retiring as President. I would like to place in nomination the name of William Hyland as delegate to the American Medical Association.

THE SPEAKER: Are there any other nominations? Two are to be elected.

J. E. LIVESAY, M.D.: I move that nominations be closed.

C. L. WESTON, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously)

THE SPEAKER: The Chair would like to ask the members of the Credentials Committee immediately to pass the ballots, and we will vote on the names of Dr. Christian, Dr. Morrish and Dr. Hyland for the position of delegates to the American Medical Assotion. You are instructed to vote for two.

G. C. PENBERTHY, M.D.: A point of order. Isn't it necessary for each delegate to have two votes. We aren't voting for two delegates, are we?

THE SPEAKER: According to the Constitution (I will ask Dr. Foster to look it up) regardless of the names submitted the two receiving the highest votes will be elected. I will ask Dr. Foster to look that up.

THE SECRETARY: This comes up every year.

THE SPEAKER: I would like to read from the Constitution: "At each annual session candidates for delegates and alternates shall be nominated in number equal to or greater than the number to be elected. Election shall be by ballot. The required number of high candidates shall be declared elected."

(Balloting)

E. D. SPALDING, M.D.: Mr. Speaker, you will increase the chances of the man you vote for if you vote for only one. (Laughter)

THE SPEAKER: The Chair does not believe your vote will be illegal if you vote for one. You may vote for one or two, but you cannot vote for more than two. Yesterday a good many ballots had to be thrown out in the Michigan Medical Service because there were too many names on the ballots. Vote for one or two.

T. K. GRUBER, M.D: Speaker, may I make an observation? Another reason why the By-Laws should be amended!

XIV—f. ALTERNATE DELEGATES

THE SPEAKER: If there is no objection, while the ballots are being counted the Chair will declare the next order of business in order, the election of alternate delegates to the American Medical Association. Is there any objection? If not, we will proceed to the election of the alternate delegates to the American Medical Association to take the place of Dr. H. H. Cummings of Ann Arbor and Dr. R. H. Pino of Detroit, incumbents. Two are to be elected. Nominations are now in order.

R. H. PINO, M.D.: Mr. Speaker, I would like to present the name of Dr. Ralph Johnson, who is the man suggested by the delegates of the Wayne County Medical Society.

I want to give some reasons. I have been an alternate delegate from Michigan for fourteen years, and during that time I have never even received a postal card from the AMA saying there was to be a meeting.

I want to call your attention to that as being rotten public relations. That is a rotten method of informing and training our men who go into a legislative field that has to do with one of the most fundamental things in American life. If we don't think so, just see how much attention the Federal government and everybody else gives to it. Yet we go along year after year, and we have a mouthpiece of the American Medical Association who does more damage to us in the way of public relations in one mouthful than this Society will do through its public relations in the next twenty years, unless we do not do something about it!

I want to come back to the nomination of Dr. Johnson: I am not going to tell you a lot of nice things about him—he is nice enough, he's a good man, he's a good internist, he's a diplomat, he will disagree with you and smile while he does it, but if the disagreement goes along long enough he has the ability to get mad. That is a quality we need.

I would like to propose something to the State Medical Society. It can't come up as new business, but it can come up as a suggestion to The Council, and it can come up as business in other years:

We are talking about our relations with the public and our relationships within the medical profession. I would suggest that when notices are sent out to the delegates of the State Society, a special letter of some kind be sent to the alternate delegates telling them it is as important that they be here as it is that the regular delegates be here. Just because it happens that one gets a few more votes than another, we need to remember that they are all good men who are sent by the Councils of the county societies, and they need to be here to hear the discussions and to carry them back. Every man who comes here as a delegate has his mind changed about a lot of things. A lot of us don't seem to have, but we do have. (Laughter)

I would also like to suggest that the Council of the Michigan State Medical Society take these younger men—Johnson, Novy and others, and pay their way to the AMA meetings, and that the regular delegates take them in hand and get them into all of the meetings they can.

I think you regular delegates will find that some of these men who are alternates can go into a huddle with you and, after listening to what is going on, can give you some thoughts you would like to have.

I am not so sure that as we have a Junior Chamber of Commerce and a Junior Republican Party, it might not be possible that some of these younger fellows could help, like the tail on the dog, and possibly can guide the dog a little bit sometimes.

This is a matter of public relations; it is a matter of common sense; it is a matter of education, and I nominate Ralph Johnson. (Applause)

THE SPEAKER: Are there any other nominations?

G. C. PENBERTHY, M.D.: I nominate Dr. Howard Cummings.

R. H. DENHAM, M.D.: I would like to second the nomination in order to say that this Society might suggest to the AMA that the weekly secretaries' letters be sent to the alternates as well as to the delegates, to keep them informed of what is going on in the AMA, so that if one of them has occasion to attend an annual meeting of the delegates of the AMA he would then be informed of what is taking place.

THE SPEAKER: The nomination of Dr. Cummings has been seconded. Are there other nominations for the position of alternate delegate? We must have at least two; we may have any number.

E. D. SPALDING, M.D.: I move that nominations be closed.

W. S. JONES, M.D.: Second the motion.

(The motion was put to a vote and was carried unanimously)

THE SPEAKER: The Chair declares that Dr. Johnson and Dr. Cummings have been elected to the position of alternate delegates to the American Medical Association.

Incidentally, the Chair was a little remiss in failing to announce that Dr. DeGurse and Dr. Barstow, Dr. Oakes and Dr. Drumond, won the election as Councilors from their respective Districts, as stipulated in the Constitution.

The next order of business is the matter of electing a President-elect. Nominations are now declared in order for the position of President-elect to the Michigan State Medical Society.

E. D. SPALDING, M.D.: Mr. Chairman, a point of order.

THE SPEAKER: State your point.

E. D. SPALDING, M.D.: The alternates must be voted on so that seniority may be determined.

THE SPEAKER: The Chair stands corrected. The Chair will ask the Credentials Committee to pass out the ballots for the voting on the alternates to the AMA. They are busy counting ballots. The Chair would like to appoint the two Dr. Oakes and Dr. Bloemendaal and Dr. Livesay to pass those ballots out at once.

Thank you, Dr. Spalding. We are voting for two. You may vote for one or you may vote for two, as you wish. The Constitution states that the name receiving the larger number of votes will have senority over the other. If you vote for two there will be no seniority; that's right.

E. D. SPALDING, M.D.: The point we are voting on is who is to be senior alternate delegate. We vote for one.

THE SPEAKER: Right. Vote for one.

J. J. O'MEARA, M.D.: Mr. Speaker, I would like to announce the result of the vote for the position of delegates to the American Medical Association: Dr. Christian received 70, Dr. Hyland received 59, and Dr. Morrish received 36.

THE SPEAKER: The Chair will declare that Dr. Christian and Dr. Hyland have been elected to the position of delegates to the American Medical Association.

The ballots have been passed for the voting on alternate delegates. The members of the Committee will please collect the ballots.

XIV—g. PRESIDENT-ELECT

While the ballots are being collected the Chair will declare the next order of business, the election of a President-elect. Nominations are now open for the position of President-elect.

E. A. OAKES, M.D.: It is a long time since I have stood up here, and I'm glad of it. It gives me a great deal of pleasure to give you the name of a man from our District who has done a great deal for us, and a great deal for you. Dr. Sladek, "Ed," as we call him, has been a real worker, and you all know it. He has probably given up more days in the past three years to the job he has been doing than any of us would ever think of giving. He has been a member of this Society for twenty-eight years. He has served for six years in the House of Delegates. He has been on The Council for nine years, the last five on the Executive Committee and the last three as Chairman of The Council.

I don't know of any man more qualified, with a record of hard work, than Dr. Sladek. A man who will produce that much and do as much work for the Society certainly will do as much for us as President-elect and later as President.

I feel the Society is very fortunate in having a man of his caliber available, and it gives me great pleasure to represent my District and present to you the nomination of Dr. Ed Sladek of Traverse City for President-elect. (Applause)

G. C. PENBERTHY, M.D.: Mr. Speaker and members of the House, I heartily endorse this nomination. Dr. Sladek's record speaks for itself. As Dr. Oakes has said, he has devoted a great deal of time to the best interests of good medicine.

I have seen him in action in his home town, and having heard what Dr. Oakes has said about his behavior and his activities in that District, I can vouch for them, too. I have seen him in action, and I am sure he is the man who will work for the best interests of our good Society.

THE SPEAKER: Are there any other nominations?

H. H. RIECKER, M.D.: Mr. Speaker, may I have the pleasure of endorsing Dr. Sladek's nomination?

THE SPEAKER: Dr. Riecker endorses Dr. Sladek's nomination. Are there any other nominations for the position of President-elect? What is the pleasure of the House?

G. C. PENBERTHY, M.D.: Mr. Speaker, I move that nominations be closed.

T. Y. HO, M.D.: I second the motion.

R. H. DENHAM, M.D.: Mr. Speaker, may I move that the rules be suspended and that the Secretary be instructed to cast the unanimous ballot for the nomination of Dr. Sladek?

THE SPEAKER: The Chair will accept that as a substitute motion, and the Secretary is instructed to cast the unanimous ballot of the House for the one nominee.

W. W. BABCOCK, M.D.: I support the motion.

L. W. GERSTNER, M.D.: I would like to have the House stand.

(Rising applause)

THE SPEAKER: The Chair would like to have Dr. Ray Morrish take over Dr. Woodward's job. Dr. Penberthy and Dr. Morrish will escort the new President-elect to the platform.

(Dr. Sladek was escorted to the platform, and the audience arose and applauded)

THE SPEAKER: I present to you the President-elect.

E. D. SLADEK, M.D.: Mr. Speaker and members of the House of Delegates, all I can say is "Thank you." I certainly will do my best for Michigan medicine. Thank you. (Applause)

THE SPEAKER: The next—

J. J. O'MEARA, M.D.: Mr. Speaker, the results of the alternate delegates to the AMA: Dr. Ralph Johnson, 56; Dr. H. H. Cummings, 24.

THE SPEAKER: The Chair will declare that Dr. Johnson and Dr. Cummings have been elected to the position of alternate delegates, Dr. Johnson having seniority of these two in the listing as alternate delegate.

T. K. GRUBER, M.D.: Mr. Speaker, may I have the privilege of the floor?

THE SPEAKER: If there is no objection, Dr. Gruber has the floor.

T. K. GRUBER, M.D.: I should like to move that this House express in an appropriate way their appreciation of the work of Tony Reeder. He has been a member of the House of Delegates of the American Medical Association and has done yeoman work for the AMA. I should like to move an expression of appreciation of this House be extended to him for his work for this Society and his membership in the House of Delegates of the AMA.

W. D. BARRETT, M.D.: I am pleased to support the motion.

(The motion was put to a vote and was carried unanimously)

XIV—h. SPEAKER OF HOUSE OF DELEGATES

THE SPEAKER: The Chair will declare nominations in order for the position of Speaker of the House of Delegates.

H. H. RIECKER, M.D.: As Chairman of the delegation from the Washtenaw County Medical Society, I wish to place in nomination the name of J. S. DeTar to succeed himself as Speaker of the House.

THE SPEAKER: Will the Vice Speaker please take the Chair?

(The Vice Speaker resumed the Chair)

E. D. SPALDING, M.D.: I second that motion, Mr. Vice Speaker.

R. A. SPRINGER, M.D.: Mr. Vice Speaker, I move that the rules be suspended and that the Secretary be authorized to cast a unanimous ballot for Dr. DeTar. I would also like to have a standing vote of thanks expressed to Dr. DeTar for the fine job he has done during this meeting.

(The motion was severally seconded)

THE VICE SPEAKER: It is moved and seconded that the rules be suspended and that the Secretary cast a unanimous vote for Dr. DeTar as Speaker of the House, and that he be re-elected to succeed himself by a standing vote.

(The audience arose and applauded)

(The Speaker resumed the Chair)

THE SPEAKER: Gentlemen, I want to say that I appreciate this. I think you have been exceedingly kind, and I am very grateful. I do feel that you have been very good in addition, because I am distinctly a freshman at this job. I particularly want to thank those members (and I am looking at the leading one) who are expert parliamentarians and who have not made it too tough. I want to thank individually the chairmen of the reference committees particularly, and those men who worked on those reference committees, because they had a tough job and they worked long hours.

I should like also to extend my thanks this year to Mr. Bill Burns and Mr. Hugh Brenneman. You know, we sit here and we think we are working hard, but we have no idea of how much work goes on behind the scenes. Also to Mr. Henry Hopp, the newly appointed assistant executive secretary. Those men are working all the time, and a great deal of work has been done in preparation for this session.

The Chair will declare the next order of business to be the election of the Vice Speaker of the House of Delegates. Nominations are now in order.

XIV—i. VICE SPEAKER OF HOUSE OF DELEGATES

R. S. BREAKEY, M.D.: Mr. Speaker, I should like to nominate Dr. Baker, not only as a personal friend but as a friend of the State Society as a whole.

THE SPEAKER: Dr. Robert Baker of Pontiac is nominated. Are there further nominations?

E. A. OAKES, M.D.: I move that nominations be closed and the Secretary be instructed to cast the ballot of the House for Dr. Baker.

A. Y. HO, M.D.: I support the motion.

(The motion was put to a vote and was carried unanimously)

THE SPEAKER: Congratulations, Dr. Baker.

Gentlemen, I believe our business is about at an end. Before adjourning the House I should like to remind you again that the exhibits—Dr. Foster, we weren't supposed to close until twelve o'clock, and I apologize for being half an hour early. Are the exhibits open now? The exhibits are open and I encourage all of you to go as a body across to see them.

(Announcements)

L. W. GERSTNER, M.D.: Would it be out of order to give the thanks of this group to our Secretary, who also has done so much work for us during this year?

THE SPEAKER: It would be very much out of order not to. I suggest we give Secretary Foster a round of applause for the tremendous work he has been doing.

(The audience arose and applauded.)

XV. Adjournment

THE SPEAKER: Gentlemen, if there is no other business, the meeting of the House is declared adjourned. Thank you, gentlemen.

(The meeting adjourned *sine die* at 11 a.m.)

MORE ANNUAL SESSION ECHOES

(Continued from Page 1380)

Barry Laboratories, Inc., by A. W. Barry, President, Detroit: "This was one of the most beneficial sessions that I have ever attended, and I want you to know how much I appreciate your support and efforts."

White Laboratories, Inc., by James H. Cupps, Newark, N. J.: "We have heard from our representatives who attended our exhibit at the Michigan State Medical Society meeting that everything was very successful. We sincerely appreciate your co-operation."

Hanovia Chemical and Mfg. Co. by A. L. Schweickart: "For a state meeting you had rather a good attendance and we were satisfied with the results. We will certainly see to it that your 1948 meeting is included in our budget."

Postgraduate Courses

University of Michigan Medical School

CLINICAL EXERCISES FOR PRACTITIONERS

Wednesday, October 8, 1947 to May 5, 1948

9:00 A.M.-12:00 NOON—Attendance at surgical ward rounds and surgical operations.
1:30 P.M.- 5:00 P.M.—Surgical Exercises arranged especially for practitioners. These will include clinics, lectures, and demonstration in General Surgery and all of the surgical specialities.
7:45 P.M.- 9:00 P.M.—Surgical staff conference in clinical amphitheater.
The fee is $50. Registration: Room 2040, University Hospital.

CLINICAL INTERNAL MEDICINE

Thursday, October 9 to December 18, 1947; January 8 to April 22, 1948. 1:30 P.M.

Arrangements have been made to meet the demands of practicing physicians for further training in internal medicine by offering a clinical teaching program every Thursday afternoon, beginning October 9 and continuing through December 18, 1947. The schedule will be resumed on January 8 and continued through April 22, 1948. Patients will be presented on ward rounds conducted by two members of the senior staff of the Department of Internal Medicine. The period will end with a conference of the entire medical staff and a review of recent interesting electrocardiograms.

The fee is $50. Limited to 40 members. Registration: 2020 University Hospital.

CLINICAL APPLICATION OF THE BASIC SCIENCES

January 5 to January 30, 1948

This course will correlate the basic sciences with clinical medicine. Lectures will cover the phases of chemistry, physiology, bacteriology, pathology, and pharmacology which are directly applied in the practice of internal medicine as well as clinical medicine. Daily ward rounds in small groups will offer practical demonstrations with patients and emphasize problems in physical diagnosis. Clinical conferences with the pharmacologist, bacteriologist, and pathologist will further aid in the correlation.

The fee is $100.00.

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Because of the importance of illustrative matter in this subject, many new illustrations have been added to this new Second Edition.

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J. K. Altland, M.D., Commissioner

START VISION CONSERVATION PROGRAM

A vision conservation program for Michigan school children is now being undertaken by the Michigan Department of Health in co-operation with numerous other agencies.

Miss Caroline Austin, a consultant in vision, has been employed by the department to co-ordinate the program in which the Department of Public Instruction, local health departments, private physicians, schools, welfare agencies, as well as private agencies and service clubs, are participating.

Surveys of children from kindergarten through high school have indicated that 20 per cent of pupils, or 260,000 school children in Michigan are handicapped by sight defects which need correction.

Fundamentals of the conservation program are: encouraging good visual surroundings in the school, screening out those who have visual defects and symptoms of eye strain and referring them to an oculist, and assuring that every child who needs glasses has them. In addition, the program will stress the importance of good general health, good visual environment in the home, early recognition of sight defects, and the avoidance of ocular fatigue. Emphasis will be placed upon making parents and teachers aware of the importance of providing conditions that promote good eye health.

Schools which wish to participate in the sight conservation program make requests through their local health department, or in areas where there is no full-time health department, direct to the Michigan Department of Health.

MEASLES INCIDENCE INCREASING

Measles, increasing in the state to where it appeared at the rate of fifty cases a day the last week in October, is expected to be still more prevalent during the winter, with 1948 a "measles year."

The department has gamma globulin, a product of the Red Cross blood plasma program, available to physicians for use in prevention or modification of the disease.

WIDER DIPHTHERIA IMMUNIZATION NEEDED

Even though the three-year upward trend in diphtheria has apparently been stopped in the past year, there are less than a half dozen among Michigan's eighty-three counties which are adequately protected against the disease, should it take an upturn.

NEED EARLY DENTAL TEACHING

Caries is attacking the teeth of one-half of the two- and three-year-old children in Michigan. The average five-year-old in the state has five cavities, and one out of every three five-year-olds has a primary tooth which needs extracting. In one Michigan city, 85 per cent of children from kindergarten through high school had caries in their permanent teeth. Approximately 95 per cent of the state's population have dental disease.

These facts shown by survey conducted by the Department establish the serious need for earlier dental care and earlier and more widespread dental health education.

MULTIPLE ANTIGENS DELAYED

Because of the delay in obtaining labels and boxes, the distribution of multiple antigens was delayed beyond the October date on which it was planned to release them.

INCIDENCE OF COMMUNICABLE DISEASE

Disease	*October 1947*	*October 1946*
Diphtheria	12	10
Gonorrhea	967	1,058
Lobar pneumonia	60	49
Measles	774	102
Meningococcic meningitis	10	9
Pertussis	641	886
Poliomyelitis	115	226
Scarlet fever	285	455
Syphilis	1,247	1,826
Tuberculosis	473	589
Typhoid fever	5	4
Undulant fever	25	8
Smallpox	0	1

MOTION PICTURES AVAILABLE

The Department has motion pictures or film strips covering approximately fifty subjects of public health nature which may be borrowed without charge. They are for both lay and professional groups.

Motion pictures cover such subjects as cancer, child health, dental health, diphtheria, dysentery, first aid, flies, food sanitation, hearing, history of medicine, immunization, industrial health, infantile paralysis, malaria, milk sanitation, nursing, nutrition, physical therapy, pneumonia, posture and walking, prenatal care, public health administration, rat control, safety, school health, sewage disposal, sight conservation, swimmer's itch, tuberculosis, venereal diseases and water supply.

Sound film strips cover such subjects as water, food handling, milk sanitation, rheumatic fever, school health and public health nursing facilities. Silent film strips include care of the baby, smallpox, Florence Nightingale and nursing, Louis Pasteur and the germ theory, Madame Curie and radium, Robert Koch and tuberculosis and Walter Reed and tuberculosis.

Requests for the use of these films or strips should be made to the local or state health department three weeks in advance where possible.

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	Per Ounce
Calories	108
Calcium	230 mg.
Phosphorus	277 mg.
Iron	6.6 mg.
Thiamine	0.44 mg.
Riboflavin	0.063 mg.
Niacin	0.406 mg.

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Woman's Auxiliary

Mrs. T. Grover Amos
President

The Woman's Auxiliary MSMS is very happy to announce the addition of two counties to the State Auxiliary membership during the month of October. The first is Calhoun County which reorganized October 7 with Mrs. John Robert as president.

The second is Mecosta County organized October 14, with Mrs. Gordon Yeo as president.

The Auxiliary also welcomes two members-at-large from unorganized counties—Mrs. Guy C. Kellar, Hastings, and Mrs. Oscar Stryker, St. Clair Shores.

Officers for 1947-48

Officers are: Mrs. T. Grover Amos of 2007 W. Boston Blvd., Detroit 6, President; Mrs. Willis L. Dixon, 1434 Thomas St., S.E., Grand Rapids, President-elect; Mrs. Albert L. Callery, 1221 Sixth St., Port Huron, Vice President; Mrs. Guy L. Kiefer, 834 Rosewood Ave., East Lansing, Honorary President; Mrs. Retla Alter, 801 S. West Ave., Jackson, immediate Past President; Mrs. Homer Stryker, 448 Inkster St., Kalamazoo, Treasurer; Mrs. W. G. Mackersie, 18205 Roselawn, Detroit 21, Secretary.

Committee Chairmen are: *Archives*—Mrs. Horace French of Lansing; *Auxiliary News*—Mrs. F. G. Buesser of Detroit; *Bulletin*—Mrs. E. Gifford Upjohn of Kalamazoo; *Finance*—Mrs. Roger Walker of Detroit; *Historian*—Mrs. Lloyd C. Harvie of Saginaw; *Hygeia*—Mrs. S. A. Fiegel of Sturgis; *Legislation*—Mrs. R. Bruce Macduff of Flint; *Members-at-Large*—Mrs. Oscar D. Stryker of St. Clair Shores; *Organization*—Mrs. Willis L. Dixon of Grand Rapids; *Parliamentarian*—Mrs. Elmer L. Whitney of Detroit; *Postwar Planning*—Mrs. Michael Murphy of Cadillac; *Press*—Mrs. Charles MacCallum of Midland; *Program*—Mrs. H. P. Kooistra of Grand Rapids; *Public Relations*—Mrs. Frederick Pietz of Saginaw; *Revision*—Mrs. A. C. Roche, Laurium; *TB Speaking Project*—Mrs. Leonard Folkers of East Lansing; *Student Loan Fund*—Mrs. Howard H. Cummings of Ann Arbor.

County Presidents are: *Bay*—Mrs. Walter S. Stinson; *Delta-Schoolcraft*—Mrs. W. A. LeMire, Jr.; *Genesee*—Mrs. L. O. Shantz; *Grand Traverse-Leelanau-Benbie*—Mrs. J. G. Zimmerman; *Houghton-Baraga-Keweenaw*—Mrs. H. G. Winkler; *Ingham*—Mrs. Robert S. Breakey; *Jackson*—Mrs. W. A. Wickham; *Kalamazoo*—Mrs. John Littig; *Kent*—Mrs. Leon E. Sevey; *Manistee*—Mrs. E. C. Miller; *Midland*—Mrs. Edward H. Meisel; *Newaygo*—Mrs. John O'Neil; *North Central*—Mrs. M. A.

(Continued on Page 1468)

Say you saw it in the Journal of the Michigan State Medical Society

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Communication

Dear Editor:

Your too long delayed editorials on "The G.P. and General Practice" in the June and August issues of JMSMS are interesting reading for one who has watched the rise and fall of the general practitioner in our larger cities.

What I have to say does not concern me personally as I am fifty-seven years of age, and my standing with our local hospitals is not too bad.

Our hospitals, St. Mary's, Blodgett, and Butterworth, are making it almost impossible for the general practitioner to treat patients in them, and he has absolutely no standing on the hospital staffs. As a result, our younger men for the most part are fast becoming specialists, so that the general work, i.e., house calls, is neglected and the osteopaths are flourishing. Only yesterday the superintendent of one of our hospitals told me, "It is our intention as soon as possible to make this a specialist hospital." This same hospital recently sent out a form letter to several doctors (some of whom have just returned from three or four years military service) saying, "As you have not availed yourself of the use of our hospital to any great extent, you were not reappointed to your former position on the staff." These same men are not allowed to treat any patient in the hospital, not even slight emergencies or normal obstetrics. Yet these same hospitals, all built in a large part by public donation, beg and gladly accept community chest funds.

Of course, beds are scarce as in most cities, but patients of executive staff members or one of the numerous medical specialty boards get priority over any general practitioner. The specialists are even fighting among themselves. Does the dear, dear public have any choice of physicians? In a large number of cases, no!

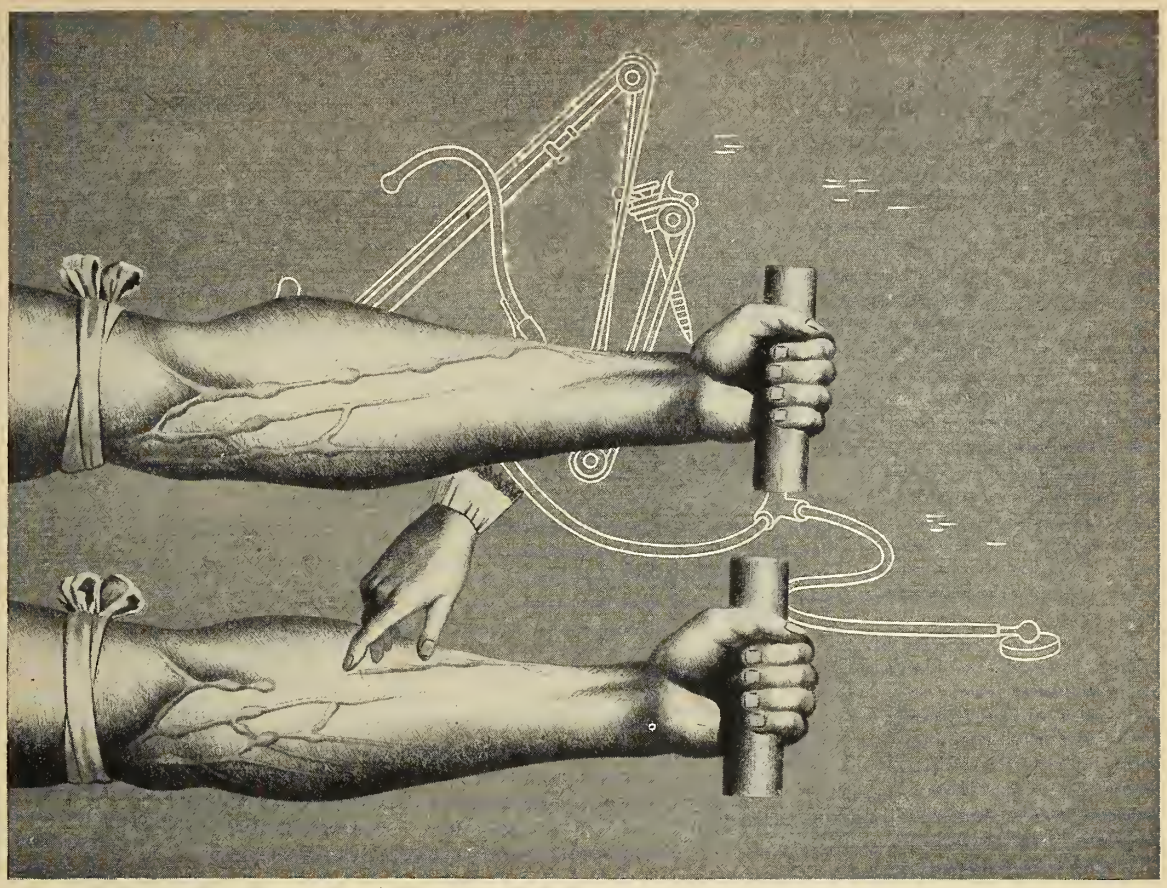
What's coming? State or Social Medicine, and it won't be because of Communism, new deal or the M-W-D Bill, but because of pure greed and selfishness on the part of organized medicine. But maybe that is what the specialists want; then all the young doctor will have to do is to sit in some hospital for three years and automatically be labeled for life as a competent specialist, when perhaps he would make a better ditch digger. The osteopaths love it. They are building new additions to their hospitals constantly.

Sincerely,

M.D., Grand Rapids

Editor's Note: For some time, and especially since the return of so many of our doctors from military practice, we have been hearing of the impossibility of general practitioners getting patients in the hospitals. This must be largely a complaint of large cities, for we have not seen that condition where we have had contacts.

Say you saw it in the Journal of the Michigan State Medical Society



The First Modern Physiology...

Medicine and Dentistry, before Harvey (1578-1657), knew little about organic *function.* But, after discovery of valves in the veins by Fabricus, his teacher at Padua, Harvey was ready for his great work.

He saw blood spurt from a snake's artery nicked *above* a ligature. When he nicked its main artery *below* a ligature, he saw no spurt of blood; and its heart swelled to bursting. He found only 4 pounds of blood in a sheep's body, but its heart was pumping out 3.5 pounds in an hour. It must *return* to the heart! It must make a *circuit!* Now a doctor could really *understand* the spread of infection and the function of major organs, and perform more intelligent surgery.

A doctor's responsibility was growing as fast as his knowledge. By 1553, he was liable for negligence, even without breach of contract. Tort law was on the way, with its newer doctrines of the doctor's liability.

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Say you saw it in the Journal of the Michigan State Medical Society

What's What

Affiliation of medical students with the AMA is being arranged, as well as a revival of the section for students in the *Journal AMA.*

* * *

J. P. Pratt, M.D., Detroit, is the author of an original article "Bleeding and the Menopause" which appeared in JAMA of November 1, 1947.

* * *

John E. Summers, M.D., Goodrich, Michigan, has an article in *International Abstracts of Surgeons,* part of Surgery, Gynecology and Obstetrics on "The Toxemias of Pregnancy," page 313, October, 1947.

* * *

R. S. Breakey, M.D., Lansing, was elected as president of the North-Central section of the American Urological Association at its October 25 meeting in Cleveland, Ohio. Congratulations, Dr. Breakey!

* * *

C. S. Kennedy, M.D., Detroit, University of Michigan Regent, gave the R. Bishop Canfield Memorial Lecture at the Rackham Postgraduate Institute, Ann Arbor, on October 25.

* * *

The Australian Journal of Experimental Biology and Medical Science, published by the University of Adelaide, price £1 per year, has articles on cystinurea, salmonella, histamine and histaminase leukemea, a valuable journal.

* * *

Michigan Reformatory of Ionia, Michigan, desires a Doctor of Medicine on its staff "whose work would be 90 per cent mental treatment and hygiene" according to Warden Joel R. Moore.

* * *

The National Federation of Small Business, Inc., polled its members on the Wagner-Murray-Dingell Bill, with

(Continued on Page 1452)

The second annual Michigan Postgraduate Clinical Institute will be held on Wednesday, Thursday, Friday, March 10-11-12, 1948, Book-Cadillac Hotel, Detroit. The general outline of this excellent Postgraduate Institute is published on Page 1410. Mark the dates of the Institute on your calendar. Attendance is a "must," if you wish to keep up with the swiftly moving science of Medicine.

Mount Carmel Mercy Hospital

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All doctors invited to All-Day Clinic. No Registration fee required. Outstanding speakers in fields of Medicine, Surgery, Urology, Obstetrics, Gynecology, Dermatology, and Medical Economics. Full program will be published later. Save the date—January 28, 1948.

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(Continued from Page 1450)

the result that 85 per cent were against the measure. Only 13 per cent favored W-M-D and 2 per cent did not vote.

* * *

Lawrence Reynolds, M.D., Detroit, was chosen as president-elect of the American Roentgen Ray Society at its Atlantic City meeting in 1947. Congratulations, Dr. Reynolds!

* * *

H. E. Perry, M.D. of Newberry, Michigan, and Lakeland, Florida, past president of the Michigan State Medical Society (1936-37), visited the MSMS Executive Office on October 24.

* * *

The new officers for the Section of Dermatology and Syphilology to preside during the year 1947-48 are Chairman, John H. Cobane, M.D., 10 Peterboro, Detroit 1, and Secretary, Herbert H. Holman, M.D., 2010 David Broderick Tower, Detroit 26.

* * *

Michigan's vivisection law of 1947 (Senate Enrolled Act No. 108) was published in its entirety in the *Bulletin of the National Society for Medical Research,* November-December, 1947. For copies, write Anton J. Carlson, president, 25 E. Washington Street, Chicago 2, Illinois.

* * *

Holiday Greetings to all members of the Michigan State Medical Society. The Editorial Board of JMSMS sincerely wishes for every member of the Society a year of good health, satisfaction in his practice, and success in his endeavors for the good of Medicine, during 1948.

The Cover

The photograph on the cover pictures the front of the Medical School building on the Indiana University campus at Bloomington, Indiana, where medical students attend classes for the first year. The second, third and fourth-year classes are held in the Medical School building in Indianapolis, a part of the Indiana University Medical Center.

* * *

The National Federation of Small Business, Inc., which is composed of independent businessmen from every section of the country, recently conducted a poll of its members on whether or not they favor S. 1320, the revised form of the Wagner-Murray-Dingell Bill. Results: *for,* 13 per cent; *against,* 85 per cent; no vote, 2 per cent.

* * *

VA hospitals will set up registrars' offices to handle all the routine paper work that nonprofessional personnel can process, to relieve doctors, nurses, and technicians of hospital paper work. Chief Medical Director Paul R. Hawley's latest directive will result in doctors of medicine and other highly trained personnel being

(Continued on Page 1454)

CHICAGO MEDICAL SOCIETY

Fourth Annual Clinical Conference

March 2, 3, 4, 5, 1948

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Four full days of lectures, panel discussions and clinicopathologic conferences presented by outstanding speakers and teachers from all sections of the country.

Scientific exhibits well worth seeing.

Technical exhibits on the newer drugs and equipment.

If you have attended previous Conferences, you probably are planning to come again in 1948. If you have not yet attended, you should make plans now to be present.

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(Continued from Page 1452)

able to devote more time to the care of veteran patients, rather than to governmental red tape.

* * *

New Health Discovery.—The latest discovery in the health field is that a U. S. Government representative is authorized to attend an ILO (International Labor Organization) Conference meeting, to be held in the near future in Delhi, India, for the purpose of *drafting a government health program* for India.

* * *

The Northern Postgraduate Tri-State Medical Association will hold its seventy-fifth "Graduate Assembly" in Findley, Ohio, on Tuesday, April 13, 1948. This session will be an outstanding affair, the program consisting of well-known physicians presenting subjects of present-day importance in many fields of medicine.

* * *

Anesthesia, journal of the Association of the Anesthetists of Great Britain and Ireland, is a quarterly publication just completing its second year. We have received a copy and are impressed by its fine worth-while papers and its eight pages of abstracts. The price is £2 per year. Address: The Association, 45 Lincoln's Inn Fields, London WC 2, England.

* * *

The International College of Surgeons, United States Chapter, will hold its Thirteenth Assembly and Convocation in St. Louis in Keil Auditorium, November 15-19, 1948. Herbert Acuff, M.D., Knoxville, Tenn., is President; L. J. Gariepy, M.D., Detroit, is Secretary; R. M. Klemme, M.D., St. Louis, is Chairman of Arrangements for the 1948 session.

* * *

"The Doctor" postage stamps.—The Michigan State Medical Society has ordered a year's supply (50,000 copies) of "The Doctor" postage stamp. Thus, during 1948, all mail from the Michigan State Medical Society will be stamped with the reproduction of the famous painting, "The Doctor."

* * *

The medical staff of Holy Cross Hospital, Detroit, is sponsoring a program for the benefit of the hospital. A 1947 Super DeLuxe Ford V-8 will be given away on January 25, 1948, in conjunction with the ceremony of unveiling the dedicatory plaques on the third anniversary of the founding of the hospital.

* * *

D. A. Van der Slice, M.D., of Flint, Director of Health of the Mott Foundation and Medical Consultant to the Flint Public Schools, was elected president of the American School Health Association at its annual meeting in Atlantic City on October 8.

Congratulations, Dr. Van der Slice!

* * *

"Doctors along the Boardwalk" appeared in *Harper's Magazine* for September. This is deVoto's viewpoint of the AMA (and of every practitioner of medicine in the

(Continued on Page 1456)

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(Continued from Page 1454)

country). You may not agree in all details with the picture he draws but it indicates the viewpoint of many laymen.

* * *

The first Michigan Rural Health Conference was so successful (held on the campus of Michigan State College, East Lansing, September 18-19, 1947) that the MSMS Committee on Rural Health is already planning the second edition of the MRHC. The co-operation of all interested groups is being sought in a combined meeting scheduled for January, 1948, at which plans for the 1948 Conference will be laid.

* * *

The AMA Council on Industrial Health will hold its Eighth Annual Congress in the Cleveland Auditorium, Cleveland, Ohio, on January 5 and 6, 1948. These dates immediately precede the interim session of the AMA, scheduled for Cleveland on January 7 and 8. For program of the Industrial Health Congress write C. M. Peterson, M.D., 535 N. Dearborn Street, Chicago 10, Illinois.

* * *

Recent appointments by Governor Kim Sigler were:

1. *Advisory Council to Board of Registration of Nurses and Trained Attendants*: C. G. Clippert, M.D., Grayling; G. F. Moench, M.D., Hillsdale; E. A. Oakes, M.D., Manistee.
2. *State Advisory Council of Health*—H. E. Wisner, M.D., and J. G. Molner, M.D., Detroit.
3. *Board of Examiners in Basic Science*—Orin E. Madison, Ph.D., and Henry F. Vaughan, D.P.H.

* * *

Mount Carmel Mercy Hospital (Detroit) Clinic Day, January 28, 1948. Doctors of Medicine are invited to attend the all-day clinic which will feature outstanding speakers in the fields of Medicine, Surgery, Urology, Obstetrics, Gynecology, Dermatology, and Medical Economics. There will be no registration fee and the full program will be published later. Reserve Wednesday, January 28, 1948, for attending *Mount Carmel Clinic Day.*

* * *

The Wayne County Medical Society is making arrangements for a Centennial Anniversary to be held in Detroit, May 3, 1948. The Committee on Arrangements includes: L. J. Gariepy, M.D., Chairman; Frank Laberson, M.D.; Frank Weiser, M.D.; Eugene Osius, M.D.; Arch Walls, M.D.; William G. Elliott, M.D.; E. C. Texter, M.D.; Donald Kaump, M.D.; Conrad Lam, M.D.; Malcolm MacQueen, M.D.; Donald Somers, M.D.; Douglas Donald, M.D.; A. H. Whittaker, M.D.; and Harry Pearse, M.D.

* * *

Sixteen new Rheumatic Fever Centers in Wayne County.—The MSMS Committee on Rheumatic Fever Control, with the financial assistance of the Michigan Society for Crippled Children and Disabled Adults, Inc., has given the green light to the opening of sixteen Rheumatic Fever Control Centers in Wayne County.

(Continued on Page 1458)

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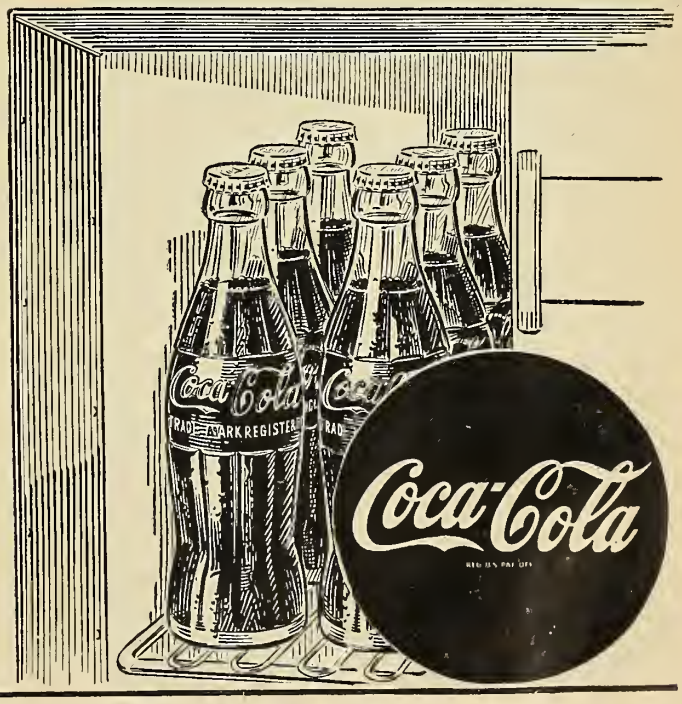

(Continued from Page 1456)

The program will be under the joint operation of the Michigan State and Wayne County Medical Societies' Committees on Rheumatic Fever Control headed, respectively, by Frank VanSchoick, M.D., of Jackson, and Norman E. Clarke, M.D., of Detroit.

* * *

U. P. Postgraduate Course in Autumn.—A week of postgraduate instruction in the autumn of every year has been arranged by the Michigan State Medical Society for its members who reside in the Northern Peninsula of Michigan. This annual course will augment the spring extra-mural lectures presented by the MSMS Committee on Postgraduate Medical Education in cooperation with the University of Michigan Postgraduate Medical Department and Wayne University College of Medicine. The autumn course was approved by the MSMS Executive Committee of The Council on October 16.

* * *

Michigan Society of Anesthetists.—The regular dinner meeting of the Michigan Society of Anesthetists was held at the Olds Hotel, Lansing, Michigan, at 6:30 p.m. on November 19. The program consisted of a panel discussion of anesthesia and analgesia in the obstetrical patient. Contributing to this program were Dr. Mary Lou Byrd, Dr. A. B. Stearns, Dr. Powers, Dr. McKersie, Dr. Van Belois, Dr. Benjamin and Dr. Kitchel.

Dr. Ivan B. Taylor of Detroit is President and Dr. Mary Lou Byrd of Grand Rapids is Secretary. Physicians interested in joining this organization may communicate with Dr. Mary Lou Byrd, Butterworth Hospital, Grand Rapids.

* * *

The Kent County Medical Society held its first annual Cancer Symposium in Grand Rapids on November 13, 1947. Featured speakers included William Boyd, M.D., Toronto, Canada, J. R. Driver, M.D., Cleveland, Norman F. Miller, M.D., Ann Arbor, James R. Miller, M.D., Hartford, Conn., Owen Wangensteen, M.D., Minneapolis, E. H. Pohle, M.D., Madison, Wisconsin, and Walter G. Maddock, M.D., Chicago.

"What is the Cancer Problem Today?" was the subject of the evening lecture by Dr. James R. Miller. The meeting, presided over by Milner Ballard, M.D., president of the Kent County Medical Society, was open to the public.

* * *

Dr. Joseph S. Lawrence, director of the AMA, Washington office, reports that 132 bills and resolutions pertaining to health and medical practice were introduced in the last Congress. Of this number, fifty-one were introduced in the Senate and eighty-one in the House. Thirty-six of these had identical companions in the other House, twenty-one were accorded hearings before Senate committees and thirty-five before House committees. Of

(Continued on Page 1460)

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(Continued from Page 1458)

those having hearings, nineteen Senate and twenty-one House bills were reported to their respective floors and fifteen passed the Senate while only eleven passed the House. Of these, three Senate bills, five House bills and one joint resolution passed both Houses and with one exception became law.

* * *

Three new members have been appointed and two old ones reappointed to the State Board of Registration in Medicine by Gov. Kim Sigler. The four-year appointments are subject to Senate approval.

New appointees were Dr. Cyrus B. Gardner, of Lansing, Sigler's personal physician; Dr. Leland E. Holly, of Muskegon and formerly of Hastings, and Dr. Cecil Corley, of Jackson. All are graduates of the University of Michigan.

They succeed Dr. J. Earle McIntyre, of Lansing; Dr. Rubie Goldstone, of Detroit, and Dr. Claude Keyport, of Grayling.

Reappointed were Dr. David C. Eisle, of Ironwood, and Dr. Franklin L. Troost, of Holt.

* * *

The Wagner-Murray-Dingell Bill and other social security legislation proposed or now on the federal statute books would cost 25 per cent of payroll, according to Elizabeth Wilson, Cambridge, Massachusetts, Associate of the Actuarial Society of America. Miss Wilson reaches the conclusion, after a careful analysis, that WMD would cost 8 to 10 per cent of the covered payroll. Other social insurance costs, she estimates, may reach 15 per cent of payroll, and adds that "to devote 25 per cent of the nation's payroll to social insurance would pose staggering economic problems."

"Socialized medicine involves many dangers," says Miss Wilson, "particularly the medical, the economic, and the political. The claimed advantages are largely illusory."

* * *

At the International College of Surgeons (United States Chapter) assembly in Chicago on October 3, 1947, the following Michigan surgeons were inducted at the convocation: Fellows: R. M. Burke, M.D., Port Huron; R. H. Denham, M.D., Grand Rapids; L. E. Grajewski, M.D., Detroit; H. M. Kirschbaum, M.D., Detroit; J. V. Lammy, M.D., Detroit; Carl S. Ratigan, M.D., Dearborn; W. A. Schafer, M.D., Port Huron; E. C. Sites, M.D., Port Huron; E. F. Sladek, M.D., Traverse City; B. F. Sowers, M.D., Benton Harbor; W. H. Steffenson, M.D., Grand Rapids; C. S. Tarter, M.D., Bay City, and C. F. Thomas, M.D., Port Huron.

Associates: J. C. Brisson, M.D., Detroit; G. M. Brown, M.D., Bay City; H. J. Burkholder, M.D., Alpena; H. K. Butterworth, M.D., Lincoln Park; F. O. Connolly, M.D., Detroit; H. J. Flaherty, M.D., Detroit; Raymond S. Halligan, M.D., Flint; Frederik E. Hansen, M.D., Detroit; Joseph Hickey, M.D., Detroit; S. L. Hileman, M.D., Ecorse; C. N. Jaekel, M.D., Detroit; C. S. Martin, M.D., Port Huron; R. J. Mendelssohn, M.D., Detroit; R. H. Proud, M.D., Flat Rock; R. G. Robinson, M.D.,

(Continued on Page 1462)

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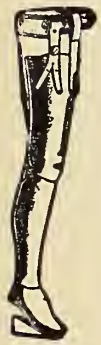

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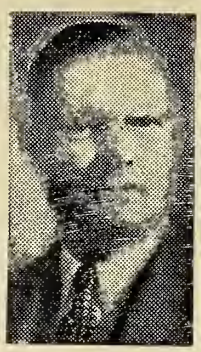

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(Continued from Page 1460)

Detroit; T. I. Roth, M.D., Detroit; M. M. Silverman, M.D., Detroit, and Otto VanderVelde, M.D., Holland.

Affiliates: M. H. Hendelman, M.D., Detroit and E. R. Sherrin, M.D., Detroit

Matriculate: Wilfred A. Huegli, M.D., Detroit.

* * *

Army personnel will be vaccinated against influenza during the fall of 1947 according to Department of the Army Circular No. 4, dated 22 September, 1947. Vaccination of all military personnel will begin during October and those entering the service prior to 1 April, 1948, will receive influenza vaccine along with their initial immunizations. Precautions will be taken to avoid administering influenza vaccine to persons having a history of egg allergy. Suspected outbreaks of the disease occurring in a military installation or command will be immediately reported to The Surgeon General. Laboratory tests will be made in the field on early representative cases to establish outbreaks. In addition to the A and B viruses the vaccine contains an A-variant cultured from the distinctive type of influenza that occurred at Fort Monmouth, N. J., last season. Inasmuch as a new strain was isolated last year, it is possible that other new strains may be demonstrated this year. The Army is on a lookout for any new strains that may occur.

* * *

The "Doctor of Medicine" radio program over Station CKLW (Fridays at 2:00 p.m.), prepared by the Michigan State Medical Society and sponsored as a public service by the Hack Shoe Company of Detroit, featured the following talks:

May 16—C. D. Candler, M.D.: "What Is the Wayne County Medical Society?"

May 23—James H. Dempster, M.D.: "Medicine Then and Now."

May 30—Alfred H. Whittaker, M.D.: "The Care of Accidents."

June 6—Baxter B. Fair, M.D.: "Their Mother's Children."

June 13—Charles J. Barone, M.D.: "The Role of Public Health Officer."

June 27—William J. Stapleton, M.D.: "So You Want to Be a Doctor?"

July 4—Lawrence Pratt, M.D.: "Cancer of the Lung."

July 11—Sidney Adler, M.D.: "Diet and Disease."

July 18—Ralph Pino, M.D.: "Medical Associates."

July 25—Dr. Douglas Donald: "Rheumatic Fever."

The July 25 program was the concluding episode.

* * *

The following Michigan doctors of medicine were accepted into Fellowship at the 33rd Convocation of the American College of Surgeons in September, 1947, at the New York session:

Robert J. Bannow, Mount Clemens; John G. Beall, Traverse City; Leonard L. Cowley, Detroit; Robert H. Denham, Jr., Ann Arbor; Kent A. Dewey, Grand Rapids; Frank Doran, Grand Rapids; Theodore S. Fandrich, Detroit; Garth H. Harley, Detroit; Henry J. Lange, Ann Arbor; Walter E. Larson, Levering; Harold V. Longyear,

(Continued on Page 1464)

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Detroit; Clyde S. W. Martin, Port Huron; Harold E. Mayne, Saginaw; Nathan D. Munro, Jackson; Victor E. Nelson, Detroit; Sheldon R. Newcomer, Monroe; Eugene H. Quigley, Dearborn; Bernard L. Rabold, Detroit; Alven A. Reske, Dearborn; James A. Rieden, Detroit; Charles S. Robb, Grand Rapids; Stanley J. Roman, Detroit; Emil M. Roth, Grand Rapids; Milton M. Rozan, Lansing; Richard C. Schneider, Ann Arbor; Richard H. Schug, Detroit; John P. Sheldon, Sturgis; James D. Sleight, Battle Creek; Carleton A. Smith, Pontiac; Russell H. Strange, Mt. Pleasant; Sylvester W. Trythall, Detroit; Jacob F. Wenzel, Detroit; Kenneth A. Wood, Detroit; Harold W. Woughter, Flint.

* * *

Organization Seminar in Berrien County. Forty-five members of the Berrien, Cass, and Van Buren County Medical Societies attended a successful MSMS "Organization Seminar" in Niles on November 3.

After a round-table discussion of county society presidents and secretaries, led by R. J. Hubbell, M.D., Councilor, Fourth District, MSMS, from 5:30 to 7:00 p.m., the dinner meeting of the Berrien County Medical Society, to which all physicians of the Fourth Councilor District were invited, was held with the following program:

1. "Big Problems Face the Medical Profession—but the Biggest Problems are Solved by Good Organization" by P. L. Ledwidge, M.D., Detroit, MSMS President.

2. "The Individual Doctor's Responsibility in Medical Public Relations and Health Education" by J. S. DeTar, M.D., Milan, MSMS Speaker of House of Delegates.

3. "The Beneficial Results of Co-ordination of State and County Medical Society Activities" by J. D. Miller, M.D., Grand Rapids, MSMS Councilor of Fifth District.

A spirited discussion period ensued.

Present at the first MSMS "Organization Seminar" of 1947 were: U. M. Adams, M.D., Marcellus; B. M. G. Anderson, M.D., St. Joseph; A. P. Bleismer, M.D., St. Joseph; R. I. Clary, M.D., Dowagiac; R. C. Conybeare, M.D., Benton Harbor; P. C. Crowell, M.D., St. Joseph; J. S. DeTar, M.D., Milan; Grover Fattic, M.D., Niles; M. R. French, M.D., Paw Paw; E. L. Garrett, M.D., Niles; F. G. Geoman, M.D., St. Joseph; Clarence Gilletti, M.D., Niles; R. L. Green, M.D., Eau Claire; P. G. Hanna, M. S., St. Joseph; I. M. Harper, M.D., Benton Harbor; R. T. Hart, M.D., Niles; N. J. Hershey, M.D., Niles; J. K. Hickman, M.D., Dowagiac; R. J. Hubbell, M.D., Kalamazoo; F. A. King, Jr., M.D., Benton Harbor; H. C. Kling, M.D., Niles; Harry Kok, M.D., Benton Harbor; C. V. Lawton, M.D., Benton Harbor; P. L. Ledwidge, M.D., Detroit; George Loupee, M.D., Dowagiac; S. L. Loupee, M.D., Dowagiac; F. H. Lindenfeld, M.D., Grand Rapids; W. R. Lyman, M.D., Dowagiac; E. A. Miller, M.D., Berrien Springs; J. D. Miller, M.D., Grand Rapids; Scott Moore, M.D., Niles; K. C. Pierce, M.D., Dowagiac; H. M. Pritchard, M.D., Niles; J. R. Ralyea, M.D., Paw Paw; G. N. Rein, M.D., Benton Harbor; F. A. Rice, Sr., M.D., Niles; F. G. Rice, Jr., M.D., Niles; B. F. Sowers, M.D., Benton Harbor; A. N.

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Steele, M.D., Paw Paw; J. C. Strayer, M.D., Buchanan; M. H. Strick, M.D., Benton Harbor; D. W. Thorup, M.D., Benton Harbor; W. R. Young, M.D., Lawton; and Edward Zwergel, M.D., Cassopolis. Wm. J. Burns, MSMS Executive Secretary, and H. W. Brenneman, Lansing, MSMS Public Relations Counsel.

* * *

Recent meetings of The Council and of MSMS Committees (from September 1, to December 10, 1947):

1. Program Committee of Michigan Postgraduate Clinical Institute, Ann Arbor, September 3.
2. Rheumatic Fever Control Committee, Ann Arbor, September 3.
3. Special Committee with Governmental Officials, Lansing, September 5.
4. Commission on Health Care, Ann Arbor, September 10.
5. Michigan Rural Health Conference, East Lansing, September 18-19.
6. The Council, Grand Rapids, September 20-21-25.
7. Committee on Hospital Licensure, Grand Rapids, September 25.
8. Executive Committee of The Council, Jackson, October 16.
9. Advisory Committee to Maternal and Child Health Bureau of Michigan Department of Health, Lansing, October 23.
10. Rheumatic Fever Control Committee, Lansing, October 26.
11. Commission on Health Care, Lansing, October 29.
12. "Organization Seminar," Niles, November 3.
13. Rural Health Committee, Lansing, November 10.
14. Executive Committee of The Council, Detroit, November 12.
15. State Interprofessional Committee, Detroit, November 18.
16. Executive Committee of The Council, Detroit, November 19.
17. Committee on Study of Medical Practice Act, Lansing, November 20.
18. Cancer Control Committee, Ann Arbor, November 20.
19. Mental Hygiene Committee, Detroit, November 20.
20. Public Relations Committee, Lansing, November 23.
21. Publication Committee of The Council, Lansing, November 24.
22. Committee on Scientific Radio, Ann Arbor, December 2.
23. Committee on Mercy Hospitals-Michigan Hospital Service, Detroit, December 3.
24. Legislative Committee, Lansing, December 4.
25. Committee on Courses in Medical Economics, Detroit, December 4.
26. Committee on Scientific Work, Detroit, December 7.
27. Executive Committee of The Council, Detroit, December 10.

THE DOCTOR'S LIBRARY

Acknowledgement of all books received will be made in this column and this will be deemed by us as a full compensation of those sending them. A selection will be made for review, as expedient.

SYNOPSIS OF ALLERGY, By Harry L. Alexander, A.B., M.D., Professor of Clinical Medicine, Washington University School of Medicine, St. Louis; Editor of The Journal of Allergy. Second edition. St. Louis: C. V. Mosby Co., 1947. Price $3.50.

The subject of Allergy is condensed and presented in understandable form, but compact in a pocket edition. The chapter on Atopy discusses the incidence, heredity and development of hay fever. Bronchial asthma and other allergies are explained, as well as the recent advances in every allergy.

A HAND-BOOK OF OCULAR THERAPEUTICS. By the late Sanford R. Gifford, M.D., F.A.C.S., Professor of Ophthalmology, Northwestern University Medical School; Revised by Derrick Vail, M.D., D.O. (Oxon.), F.A.C.S., Professor of Ophthalmology, Northwestern University Medical School, Chicago, Illinois. Fourth edition, thoroughly revised, with 66 illustrations. Philadelphia: Lea & Febiger. 1947. Price $5.00.

Doctor Vail has undertaken a task of momentous proportion in his attempt to preserve Doctor Gifford's book on ophthalmology, with all its excellent features, and yet make the new book up to date and modern as to treatment and philosophy. The task has been accomplished, and this book is both Gifford and Vail. It is purely therapeutic, giving the drugs and remedies used, with careful analysis of their action. Good advice is given with regard to treatment of glucoma—especially, not to depend on remedies too long, losing the benefit that might be given by surgery. The book is fascinating, and one finds it difficult to lay it down.

COMMUNICABLE DISEASES. By Franklin H. Top, A.B., M.D., M.P.H., F.A.C.P., Medical Director, Herman Kiefer Hospital; Clinical Professor of Preventive Medicine and Public Health, Wayne University College of Medicine; Extramural Lecturer in Infectious Diseases and Epidemiology, School of Public Health, University of Michigan; Consultant, Preventive Medicine Section, Surgeon General's Office, United States Army, and Collaborators. With 93 text illustrations and 13 color plates. Second edition. St. Louis: C. V. Mosby Company, 1947. Price $8.50.

Doctor Top has again produced a most readable and useful book intended for the use of persons who are to come in contact with communicable diseases, and tells the responsibilities, methods of diagnosis and treatment. No one is better qualified to outline this group of diseases, and he has chosen as collaborators in twenty subjects eleven men from his home state of Michigan. The text gives half a page to the question of tonsillectomy and adenoidectomy and poliomyelitis, and calls attention to the more serious cases under such circumstances, but qualification is made that "the evidence had been accumulated in a manner not acceptable statistically, for the group studied, namely, tonsillectomized poliomyelitis patients, is a highly selected one." The book throughout is fair in its reasoning and deductions. We are greatly pleased.

SYNOPSIS OF OBSTETRICS. By Jennings C. Litzenberg, B.Sc., M.D., F.A.C.S., Professor Emeritus of Obstetrics and Gynecology, University of Minnesota Medical School, Minneapolis. With 157 illustrations, including five in color. Third edition. St. Louis: C. V. Mosby Company, 1947. Price $5.50.

For a synopsis, this book is quite complete. It is pocket size, but contains over 400 pages of well-written and well-selected text. The whole term of pregnancy and

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delivery is outlined clearly and with sufficient illustrations to make the text easily understood and followed. Chemotherapy is credited with its importance in the infections of the puerperium. The normal course of pregnancy and labor is given, but time is also spent on the complications, the diagnosis of position of fetus, and anticipation of preventable troubles.

New and Nonofficial Remedies, 1947. Containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on Jan. 1, 1947. Cloth. Price, postpaid, $3.00. Pages 749. Philadelphia: J. B. Lippincott Co., 1947.

Although the latest edition of *New and Nonofficial Remedies* has some eleven pages fewer than the 1946 book, its increase in size, due to the heavier paper used, and its change of color—dark green to bright red—combine to make a striking contrast with the earlier annual volumes. The book is now published by J. B. Lippincott and Company, though it is still issued under the direction and supervision of the Council on Pharmacy and Chemistry. Another innovation is the relegation of the statements of tests and standards to the back of the book, which makes the text more convenient and usable for the physician, for whom it is primarily intended. It is understood that supplements to the annual volumes will no longer be issued. The physician who is interested in current acceptances can keep track of these as the descriptions are published in the *Journal of the AMA,* or may inquire about them by addressing the Council's office at AMA headquarters. Several medical and pharmaceutical journals now carry lists of currently accepted products.

There appears to be no very extensive revision in the various general articles or chapter head discussions, although several new monographs have made their appearance and others have been revised to reflect current medical opinion. One notes the appearance of a new

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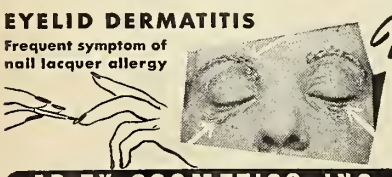

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chapter, "Unclassified Therapeutic Agents," which includes the monographs on Gold Compounds and Iodine Compounds for systemic use. This is in line with the policy adopted some years ago of classifying accepted preparations according to pharmacologic action and therapeutic use.

Attention is called to the amplification and indexing of the section devoted to the statement of the Council's Rules. This should be of great assistance to manufacturers in the presentation of products for Council consideration and is no doubt inspired by the recent marked increase in the number of pharmaceutical concerns asking Council recognition.

The descriptions of some thirteen new preparations appear in this volume. This excludes, of course, brands or dosages of already accepted agents. Among those preparations noteworthy of mention are the pertussis vaccines and vaccines representing combinations of pertussis with diphtheria and tetanus organisms; the new histamine-antagonizing agent, Benadryl Hydrochloride Elixir (Diphenhydramin Hydrochloride Elixir); Furacin (Nitrofurazone) a new topical anti-infective agent; Streptomycin; Heparin Sodium; Parenamine, a new casein hydrolysate; Thiouracil, an antithyroid agent; Naphuride Sodium (Suramin Sodium), a new trypanocide; and Tuamine (Racemic 2-aminoheptane), a new vasoconstrictor. One notes the increasing appearances of generic designations in conformance with the revised Council's rules on acceptance of agents bearing protected or trademarked names.

New and Nonofficial Remedies remains a most valuable and authoritative compendium of modern rational therapeutics. With successive editions, it becomes more useful and accessible to the physician and to all those interested in the use, preparation, or manufacture of drugs.

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(Continued from Page 1442)

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CORRECTION OF OMISSION

The chart shown below was inadvertently omitted from the article on "Prostatic Surgery—A Review of 100 Consecutive Cases" by R. J. Hubbell, M.D., and R. N. Kilgore, M.D., which appeared on pages 1279-1282 in the

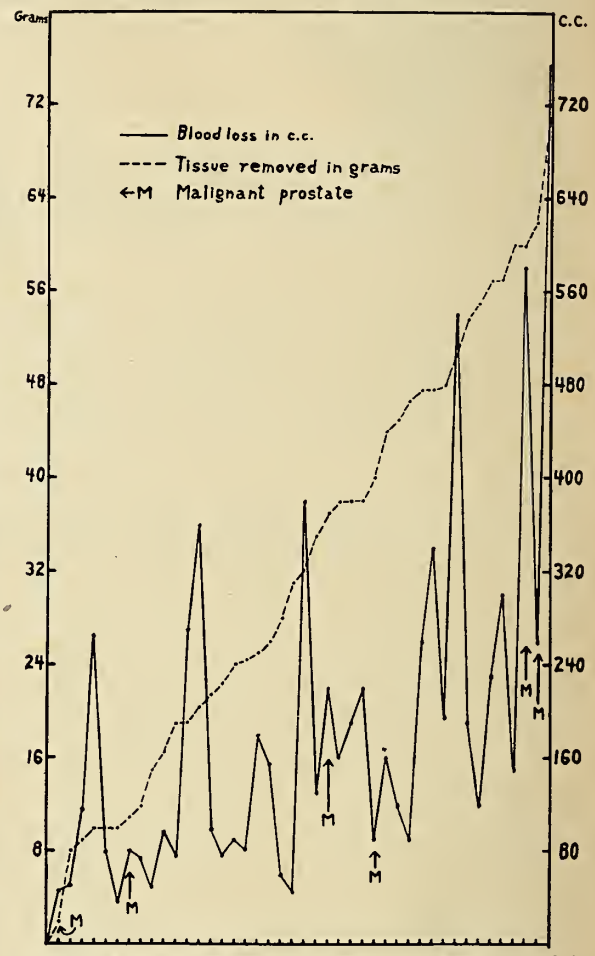

Fig. 1. Blood loss in respect to amount of tissue removed in forty-three cases of prostatic resection.

November issue of THE JOURNAL. In discussing the technique and results of prostatic surgery by the transurethral route, the authors referred, on page 1282, to Figure 1 as "showing the blood loss in respective cases with increasing amounts of tissue removed."

In their article, Doctors Hubbell and Kilgore discussed diagnosis, preoperative care, and choice of operation for patients requiring resection of the prostate gland. Blood loss in transurethral resections was determined according to the method described by Nesbit and Conger in the *Journal of Urology,* 46:713-717, 1941.

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